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MISSISSIPPI MEDICAL MONTHLY

OFFICIAL ORGAN OF
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AND ITS COMPONENT SOCIETIES.

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MISSISSIPPI MEDICAL MONTHLY

VOL. XVI. MAY 1911. NO. 1

PRESIDENT'S ADDRESS.
MISSISSIPPI STATE MEDICAL ASSOCIATION.

J. W. YOUNG M.D.,

GRENADA.

Ladies and Gentlemen and Fellows of the Mississippi State Medical Association, I greet you: I greet the ladies first because they are the best friends the doctor has; I greet you doctors because you have left your homes and are here spending your time and money to learn more of how to prevent and cure diseases and relieve human suffering. I wish now to greet and congratulate myself because I have been so highly honored by this Association by being called to the chair as president, for I declare to you here and now that I had rather be the president of the Mississippi State Medical Association than to be the governor of the state.

The Mississippi State Medical Association was first organized in the year 1856. All of the old Guard, who were the first members, have long since gone to their reward. Since organization there have been about forty-four presidential addresses and hence it is somewhat difficult to deliver an address without thrashing over some "old straw". It is, therefore, my purpose on this occasion to serve you a mixed diet, which I hope will not give you mental indigestion or nervous prostration.

I thank God that every real true physician is a gentleman, and an optimist, and an altruist, a "jolly good fellow", and an all round good citizen—loyal to the flag, loyal to the courts, loyal to his patrons, loyal to everything that is good and true, but alas! alas! in so many instances not loyal to his fellow-doctors, or his State and County Medical Societies. We are altruists for everything and everybody except each other. Why can we not be as colleagues rather than hot competitors? Instead of knocking, why can we not occasionally, at least, take a fellow-doctor by the hand and say "God bless you, my brother, I wish you well and hope you are prospering?"

There is no man in any community more valuable to the public than a good, reliable physician. Others may bring personal comforts, wealth and material conveniences, but upon the doctor the people must rely to guard their physical welfare, without which wealth would be of little value. To keep their loved ones here a little longer that their companionship may be enjoyed; to defend the little ones from the shafts of the arch enemy; to stay the course of the deadly epidemic; to preserve the young and old, life, health and happiness. In mere money, the value of his services can never be counted.

What advantage is abundance of food if one cannot have the relish of health to enable him to enjoy it? Or the finest of clothes to hide a diseased body? Or the most enchanting amusement whilst the nerves are twinging with pain? Or the pleasure of general society when one's own dear ones are mouldering in premature graves?

In a few words, what would a person accept in exchange for good health and long life for himself and family? Or what can recompense a community for the loss of a thoroughly competent physician and sanitarian? Lest some may question the estimate we place upon professional services, let us examine some of the proofs upon which such claims may rest. By improvement in medical and surgical treatment, and sanitary science, in the past hundred years, the death rate per thousand of population has been reduced from forty-two to twenty-one. The average length of human life has been increased from thirty-three years, in 1800, to above forty-five at the present time. This refers only to the preservation of life itself, yet how much in addition may be said of the disease and suffering thus saved? Compare also the condition of nations in which the science of medicine has reached its highest development to-day with those that are yet in the gloom of ignorance and superstition. A medical writer from Syria, relates the details of an epidemic of cholera in that country, in which a mortality of ninety per cent. of those attacked occurred among the Mohammedan fatalistic faith, while among those who abandoned theology and adopted scientific treatment it was pretty generally brought under control and nearly all of the patients saved. Medicine in all ages has attracted into its ranks the most self-sacrificing members of society. Medical men stand alone on the earth, among all others, striving with their whole might to extinguish their own business. They preach temperance, virtue and cleanliness, knowing well that when people come to follow their advice their occupation, like Othello's, is gone. The time has come when the

medical profession must wake up to the fact that it has been very largely ignored in the past. The heroism displayed and martyrdom suffered in the medical profession will never be known. There is a quietness about it that distinguishes it as true heroism. We never hear much of the many instances of blood poisoning from treating a septic wound; of the brave stand against the most deadly epidemics, courting death in the most loathsome forms, away from the comforting touch of loved ones, that the sick and dying may not have to fight alone their battle with the pestilence. We may have the pestilence, when all others flee; we may remain firm at our posts when death is more imminent than it ever was on the battle field, but who sings our praises? Does the world know who the physicians were who fell in the deadly plague at Sandusky, Ohio, in 1848? Does the world know or care who the physicians were who gave up their lives in the fearful epidemic of yellow fever which visited our own beloved state in 1878? Does it know who rushed in to fill their places? And of those who survived, can it designate one? Did they survive to receive fame? Yet those men were braver than the bravest military leader, for theirs was a bravery unsupported by excitement or by the hope of fame. Ah! methinks, in my mind's eye I see them now leaning over the battlements of heaven waving their salutations to us tonight. Methinks I hear them saying, "We gave, we gave our lives for you, what hast thou done for our loved ones left on earth?" And alas, we have to wave the answer back—nothing, nothing, absolutely nothing. What a true physician could not be hired to do for all the money the world could offer, he will do joyfully and without expectation of reward, from the higher sense of duty and his love for mankind.

A writer, in speaking of the "Spirit of martyrdom", which nerves the profession in the hour of peril and dismay, pays the following beautiful tribute to physicians: "But why should I multiply instances of courageous charity? They are so common, so much a matter of course, that to perform them is no longer regarded as praiseworthy—to refuse to do them alone excites attention and that to incur censure." The physician's whole endeavor is along the line of humanity. The good old country doctor gets to the point where he absolutely thinks it a sin not to respond to every call—pay or no pay—and he goes through heat and cold, through rain and shine, day and night, facing winter's blast and summer's heat, and at last he wears out and lays him down to die, and oftener than otherwise leaves a helpless, penniless family.

A great philanthropist has given eight million to a hero fund. It goes to the families of those who lose their lives in an

effort to save the lives of others in mine disasters, or in storms at sea or in great fires. Think of the physicians all over the land who have given up their lives in efforts to save others, often leaving loved ones in penury and want. Has anyone ever said that they were heroes, or has any one ever proposed that their dependent ones should share in a hero fund? Nay verily. I am an advocate for building monuments. We build monuments to the great scholars, statesmen, musicians, poets and soldiers. If I had my way I would build a monument in every county in every state of the late Confederacy to the Confederate soldiers who died in the defense of home and right. I would also erect one, whose spire would keep company with the stars, to the noble women of the Confederacy. The soldier goes forth to battle, to fight and kill his fellow man. He either fills a hero's grave or else returns to his home a living hero, for whom every one is ready to kill the fatted calf. The physician walks amid the ruin and desolation of pestilence; he goes forth to dare and do in a supreme effort to save the lives of his fellow men. Collectively he has saved the lives of hundreds and thousands. Think of the hundreds and thousands of still-born children who would have filled untimely graves but for the timely aid and skill of the family physician. Think of the millions of lives that have been saved by vaccination; think of the thousands of children that have been saved by the antitoxins; think of the thousands who are to-day being saved from untimely graves by and through the recent discovery of medical and sanitary science. Think of what Reid and Carroll and Lazear did for mankind at Havana in subjecting themselves to the deadly venom of yellow fever to prove the mosquito origin of same. And yet no one calls the discoverers of all these things heroes, or suggests a monument to any of them. Think of what Jenner and J. Y. Simpson, and Marion Sims, Crawford W. Long and Ephriam McDowell and Koch and others have done for the world in the discovery of vaccines, in the discovery of anesthesia, and in performing what was then thought to be impossible operations, which have been the means of saving the lives of hundreds and thousands?

Nearly every organization of any kind has a pension fund. All Christian denominations provide a fund for their aged and superannuated preachers. A fund is provided to pension all college professors after twenty-five years of service in the schoolroom. All United States judges, from highest to lowest, and all army officers, whether they have seen any service or not, are permitted to retire on a pension at sixty-five years of age. Every Union soldier—every bum and camp follower—is the recipient of a monthly stipend from Uncle Sam's treasury.

A good physician who has literally worn himself out toiling and working to save the lives of others, when he is no longer able to work, has any one ever been heard to even suggest a pension for him? Nay, verily. "Earth's heroes who have gone down in battle or who have been sacrificed to maintain their solemn convictions of duty to country or religion, deservedly receive the honor and praise given them. The hero dead who sleep in the National or Confederate cemeteries of the land are rightfully held in loving remembrance by the people of the section for which he fought and died, and no one calls in question the homage paid them in holding them dear to memory", but there are other heroes just as deserving of praise, notably the many true and noble physicians who have died in the line of every-day duty, and gone down to death in the fulness of loyalty to that duty.

Since writing this paper I noticed an editorial in the Commercial-Appeal which is so in keeping with the ideas I have tried to express that at the expense of wearying you I beg leave to read it.

"Medical Martyr.

"In times of war we discuss the deeds of valor of the soldiers who face the fire. In times of peace we look around for heroes and award a Carnegie medal to the girl who saves a life, or the boy who prevents a panic. We are a nation of hero worshippers. We are looking for man or woman whose deeds of bravery can furnish a topic for eulogies and praise poems. We seem blind for the greater heroes, who, for the most part, go unhonored. The medical martyrs go on unpraised to their final rest, laying down their lives for the great common cause of mankind. These medical martyrs are to be found in every clime and country. Without ostentation they enter the very jaws of death and too frequently give up their lives for the great cause in silence, without a murmur.

"In the excitement of battle men of arms forget danger. These medical heroes have no such stimulating excitement to make the end easier. They enter the presence of death calmly, with a full consciousness that they may not escape alive. They are cool, collected, conservative. They never flinch.

"Two young physicians in New York last week yielded up their lives testing the value of meningitis serums. Their death was in line with duty. Others working to discover the eventual cure had perished before them. Other physicians will follow, but some day the serum will be discovered and humanity will be spared one of the most dreadful deaths known to the medical world.

"Each day, each week, brings additional news from the plague-stricken districts of China and Russia. Ninety-eight cases out of every hundred are fatal. The physicians know this, but when the cry went up for medical assistance the trains were filled with these heroes, who knew when they said good-bye the chances were against any possible return.

"In times of epidemic it is the physician who is always the first to volunteer. Nurses come next."

It was long ago decided that you have no working hours that anybody is bound to respect. Nothing, except extreme bodily illness, will excuse you for refusing to help a man who thinks he may need help any hour of the day or night. Nobody will care whether you are in your bed, bath or theater, if any of the children of men have a pain or hurt, and in all times of flood, thaw, famine, plague, pestilence, battle, murder or sudden death it will be required that you report for duty at once. You must save others, it is nowhere recorded that you may save selves. You go on duty at once; you stay on duty until strength fails or conscience relieves you, whichever may be the longer period.

Have you heard of any legislation to limit your output; any bill for eight hours a day for doctors?

It has been seen how great is the pressure upon the doctor of to-day. Not only are there too many physicians, not only is the competition so severe that average fees remain low though rents and prices rise, but the cost of training increases, the cost of maintaining an office increases, and the profession becomes commercialized. There never was a time when the scrupulous, ethically-minded physician was subjected to so many forms of pressure.

In a great many places you will find here and there a physician who places a low estimate on his professional services and he becomes in common parlance a "cut rate" doctor. Again, I have heard that it is the practice with some doctors to send their patients to certain specialists and the specialists will charge a good fee, and send the doctor who referred the patient to him what might be termed a "rake-off". Of course the doctor who will do this will oftentimes advise an operation, whether it be needed or not—thus actually bartering in human life in order to add to his exchequer, and bring cheer to his commercialized soul. I sincerely trust that no member of this Association has entered into any such an unholy alliance as this, for I can't for the life of me see how any real, true physician could for a moment entertain such a proposition. I wish here to direct your attention to several articles on this subject in the

Journal of the A. M. A., of March 11th., and hope you may all read them. They cover the ground fully.

Finally, my dear doctors, in my feeble way, I have held up before you the life and character of a true physician—the important place he occupies in society—the influence he should have in most all the affairs of men, and I have told you of his services to the public and to his country, and I have gently hinted at what the public ought—but don't—do for him. This leads me to the inquiry, why is it that we as physicians, individually and collectively, have so little influence, and fail so often to get the ear of our legislators?

We have never asked for anything for our own personal benefit. All that we have ever asked for was looking to the general welfare of the commonwealth, and rather to our own financial detriment than otherwise. Again I ask, why is it? My diagnosis is this: it is because of the petty jealousies and the knocking in our own ranks. We are never a unit on anything. As an instance: several years back this Association passed a resolution declaring that we would not examine for any of the old line insurance companies for less than five dollars, and only a few weeks since an agent of one of the big companies told me that they have an examiner in nearly every city and town in Mississippi and are only paying a minimum fee of three dollars. We always agree to disagree, and hence a "house divided against itself must—as a matter of course—fall". Thus by our own action are we discredited by the public at large. Why was it that Drs. Kendrick, Rogers, Rowan and others accomplished so little in their efforts as members of the legislature, in regard to things medical; why was it that Drs. P. W. Rowland and Sutherland and E. F. Howard and D. W. Jones and others so signally failed in their efforts before the last legislature; why? It was because the medical profession of Mississippi folded their arms and, in the language of Dr. Gray, "went fast asleep" and failed to back them up.

If somebody's old dun cow gets covered with ticks, at once an appropriation is made to eradicate the same. If somebody's old gray horse takes the glanders it is ordered to be killed, and at once an appropriation made to pay the owner. If somebody's old chicken-eating sow takes cholera at once an appropriation is made to stop the spread of the disease. But when we go before the legislature and tell them that three thousand Mississippians are annually dying from the Great White Plague, and half as many from typhoid fever—both preventable diseases—and ask for an appropriation to stay the spread and ravages of these diseases, the door is slammed in our faces and we are

charged with the fact that as physicians we cannot agree as to what we want.

Then, my dear doctors, on this occasion and in this presence, I plead for harmony in our ranks—I plead for better feeling towards, and more love for each other—I plead for a fuller exercise of the virtues and graces which should characterize the life of every true physician—I plead for a greater interest in our County and State Associations. The very youngest of us have but a very few years on earth, then how much better we must feel when we come to die to know that we have always loved our fellows—to know that we have been kind and loving colleagues, rather than ugly and mean competitors.

And now, as we shall return to our homes, let us remember that post mortem praise or kindness will never soothe an aching heart. When we see a brother down and struggling, let's reach down and help to pull him up. Let's give each other flowers whilst we live—they can do us no good on the mounds which will be made over us when we are gone. As we shall go in and out before each other let us take Ben Franklin's advice: "Be at war with our vices, at peace with our neighbors, and let every year find us better men."

"Let us live for those who love us,
Whose hearts are kind and true;
For the heaven that smiles above us
And awaits our spirits too;
For all human ties that bind us,
For the task by God assigned us,
For the bright hopes left behind us
And the good that we can do.
For the cause that lacks assistance,
For the wrong that needs resistance,
For the future in the distance,
And the good that we can do."

Returning to our respective communities and resuming our work, as we day by day shall be called into this and that sick room, let us not hesitate to ask the good Lord to go in with us. It will pay. And at last when our worn out bodies can go no longer—when we shall come to the banks of the dark river —when we shall lay down to die—we can extend our feeble hands toward heaven and say, "Lord, I am at my journey's end; I have fought the good fight; I have done my dead level best. Now, Lord, take me to where all good doctors are—take me to Thyself." And all will be well.

*APOMORPHIA HYDROCHLORATE—ITS USE AS AN ANTI-SPASMODIC.

L. D. HARRISON M.D.,

CLARKSDALE.

Apomorphia is an artificial alkaloid prepared from morphine by heating the drug in a closed tube with an excess of hydrochloric acid. This forms a whitish crystalline powder. This powder is seldom used as a medicine, but apomorphine hydrochlorate, the drug in use, is formed by adding a small quantity of hydrochloric acid to apomorphine in solution. It is of a grayish white color, without odor, having a faintly bitter taste, acquiring a greenish tint when exposed to light and air and is soluble in forty-five parts of water or alcohol. If the drug turns green in solution it should not be used, as it is impure. The solution should always be freshly made when needed and the tablets kept in an amber-colored bottle to keep them from being decomposed by light. This drug acts as an emetic through its effect on the vomiting center, the medulla, and this is the case hypodermatically or by the mouth. It is superior to all other emetics because it is more rapid in its effects, non-irritating to the stomach, and less depressing to the circulation when freshly prepared.

This drug was first introduced to notice by Dr. S. J. Gee in St. Bartholomew's Hospital in 1869, when it was used as a powerful emetic.

In 1875 Dr. Walter G. Smith called attention to its use as a valuable emetic in an article published in the *Dublin Journal of Medical Science,* in which he says the physiological action on the pulse agrees with that observed under the production of nausea and vomiting by other means, acceleration before emesis takes place and subsequently a slight depression with a speedy return to the normal. In most cases the administration is followed by an irresistable desire to sleep.

It is rapid, simple and harmless, while the facility with which it can be administered by hypodermic injection fulfills a therapeutic want adopted for special circumstances, the medication of children and the insane.

Dr. A. Routh, in Dabell's Reports of 1876 says: "If only the certainty, rapidity and absolute safety of apomorphia hydrochlorate were known, it would undoubtedly form part of every practitioner's paraphernalia."

Sajous says: "Apomorphia is doubtless the most reliable

* Read before the Clarksdale and Six Counties Medical Society.

of our emetics and the one which acts most rapidly, but the effects obtained depend greatly upon the quality of the drug used. Bad effects of various kinds have been reported, including, besides those added to the normal action of apomorphia, marked depressions. This latter has occasioned a certain amount of distrust on the part of the profession, which, however, has no reasonable basis, provided a pure drug is used and proper precautions are taken; the most important of which is to prepare the solution at the very moment of administration."

According to Carmichael, who gives the experience of pediatricians, it "cannot be too highly esteemed as an emetic for children". It is on account of the anti-spasmodic effect of this drug that I have been induced to write this paper.

In 1885 Dr. Bumford of Calcutta used it in tetanus in doses of one-tenth to one-fourth grain hypodermically twice or three times a day, and the results were very satisfactory, curing two or three cases on which it was used. In 1894, Dr. Balm in the same hospital had a very unusual case of hiccough in a man of fifty years of age. He had suffered from it for six months and the acts numbered thirty to forty per minute. The patient was reduced to a skeleton. He had taken all the usual remedies used for such affections and without the slightest cessation or improvement. Dr. Balm gave him hypodermatically one-fourth grain of apomorphia hydrochlorate and in less than three minutes the symptoms subsided and he was not troubled with them for two days. On the third day they returned again, but were less troublesome than before. Apomorphine, one-fourth grain, was again administered. There was vomiting and attempts at vomiting for twelve hours, but the hiccough never returned and the patient made a good and speedy recovery.

I have often used this drug with marked good effect in hysteria. I recall a case I had a few days ago—a robust woman about thirty years of age suffering with a very violent form of hysteria, rolling and tossing in bed with three or four people trying to hold her down. I administered one-tenth grain of apomorphia and in ten minutes she was resting quietly. This injection was followed by a brisk purgative and I never heard of her having another attack. In the delirium of acute alcoholism when the patient is very "obstreperous", not knowing, or pretending not to know, what he is doing, and it takes three or four men to control him, nothing relieves his distress and the distress of his family and neighbors as the administration of one-tenth grain of apomorphia. The injection is followed by free emesis, complete relaxation, and the patient lapses into a quiet sleep, and when he awakes he is relieved and a sober man.

This treatment, followed by the elimination, completes the cure for the time.

This drug affords speedy relief in croup and capillary bronchitis in children without causing violent vomiting. I have used it in spasmodic croup in children of two and three years of age hypodermatically in doses of one-twentieth to one-tenth of a grain with the effect of relieving completely the spasmodic trouble and not causing any nausea at all and no bad effect. Young children are not so easily affected by this drug as older persons. The nerve center on which this medicine acts is not so well developed as in the adult, therefore, they stand larger doses in proportion to their age and weight.

The greatest advantage that I have found in the administration of apomorphia as an anti-spasmodic is in the convulsions of children—those convulsions that we find in young children with high temperature, when we find the little one with one convulsion succeeding another in rapid succession, and it is impossible to administer remedies of any kind except hypodermatically. In those kinds of cases which we often diagnose as congestion of the brain or malarial congestion due to excessive high temperature, apomorphia is the remedy. By administering one-tenth grain the child's condition is changed in five or ten minutes and instead of the rapid and jerking respiration and tetanic convulsions we have a slight nausea followed by a quiet sleep, skin bathed in perspiration, not that of exhaustion because apomorphia has had no bad effect on the heart's action and circulation. If this administration of the drug does not relieve in twenty minutes it may be repeated. In very violent cases I have had to repeat the injection two or three times. After three injections the child becomes rational and the administration of eliminatives generally completes the cure.

Mississippi State Medical Association.

MINUTES OF THE HOUSE OF DELEGATES.

The House of Delegates of the Mississippi State Medical Association was called to order in K. of P. Hall, Jackson, by President J. W. Young, April 10th. 1911, at 2:30 P. M.

On roll-call the following responded: Sessions, of Adams, Acker of Claiborne, Hosey of Clarke, Scudder of Issaquena, Lewis of Jefferson, Kittrell of Jones, Elliott of Marshall, Boyd of Monroe, Cooper of Newton, McCoy of Pearl River, Brougher

of Quitman, Willson of Warren, Stone of Washington, Pou of Wayne, Councilors Dye, Williams, Coker and Ullman, President Young and Secretary Howard.

The Council being called on for a report asked for, and was granted, further time.

The secretary read his report as follows:

Secretary's Report To The House Of Delegates Of The Mississippi State Medical Association.

VICKSBURG, MISS., April 3rd. 1911.

To The House Of Delegates,
Mississippi State Medical Association:—

Gentlemen:—Beyond routine work your secretary has but one item to report. In December our good friend and treasurer, Dr. Sutherland, was stricken by a serious malady and like the wise man he is prepared to "set his house in order". At his request I went to Rosedale and there met Dr. L. B. Sparkman of Cleveland, whom President Young had appointed to fill the vacancy caused by Dr. Sutherland's resignation. We audited the books and Dr. Sparkman took charge of them and I returned to Dr. Sutherland his bond, receiving a similar document from Dr. Sparkman. In this connection, at the request of Dr. Sutherland, I have the honor to present an amendment to the by-laws providing for the bonding of the treasurer by some bonding company, the Association to pay the cost of such action. This amendment constitutes Exhibit A of this report.

As Exhibit B are presented the books relating to the financial side of the secretary's office for 1910 and 1911.

Exhibit C consists of such information as the secretary has been able to collect concerning the members who have died in the past twelve months.

Our membership for 1910 was twenty-seven less than the preceding year. It is too early to predict our numbers for 1911, though the first thirty-two counties reporting have shown a slight gain over last year.

There is a communication from the A. M. A., Exhibit D, that requires consideration since it contemplates quite a change in our methods of organization.

Respectfully submitted,
E. F. HOWARD,
Secretary.

The chair appointed Delegates Mitchell of Pontotoc and Cooper of Newton and Councilor Coker a committee on the secretary's report.

The constitutional amendments offered at Oxford were called up and passed.

The secretary offered the amendment to the by-laws, contained in his report, suggested by Dr. Sutherland, as follows:

To amend the first sentence of Chapter VII, Sec. 3, of the by-laws so that it shall read as follows:

"The treasurer shall give bond in amount equal to the maximum amount in the treasury during the year preceding his election; the bond to be furnished by some reliable guaranty company to be selected by the council and the Association to pay the entire expense of the procedure."

Treasurer Sparkman read his report as follows:

Treasurer's Report.

Dr. H. L. Sutherland, our elected treasurer, was stricken with partial hemiplegia, or crutch paralysis, during the last days of December 1910 and, fearing the prognosis, thought it best to release himself from all business responsibility and tendered his resignation to our president, Dr. J. W. Young, who accepted it and appointed me to fill the unexpired term, which dates from Jan. 16th. 1911 when I met Dr. E. F. Howard, our secretary, at Dr. Sutherland's home in Rosedale and took charge of the treasurer's books and the balance of cash on hand, amounting to $1,319.72.

I have here the book and transcript of it, showing the receipts and disbursements of the treasurer since the books were audited one year ago, which I will now proceed to enumerate:

RECEIPTS.

1910.			
April	13.	To balance in Treasury	$ 672 40
	14.	To Check P. W. Rowland, Chairman Legislative Committee, Balance	261 15
	21.	To Check E. F. Howard, Secretary, Dues to date	1,864 10
1911.			
Jan.	7.	To Check E. F. Howard, Secretary	90 00
		Total	$2,887 65

DISBURSEMENTS.

April	15.	By Check E. F. Howard	567 71
	19.	By Check H. L. Sutherland	7 00
	28.	By Check Secretary for badges	30 00
	28.	By Check Mississippi Printing Co.	88 36
	28.	By Check E. F. Howard, Secretary, expense	37 96
	28.	By Check J. C. Adams	15 00
May	5.	By Check T. C. Newsom	10 00
	5.	By Check Clarke & Co.	3 75
	5.	By Check J. S. Ullman	3 95
	5.	By Check F. J. Heintz, Stenographer	75 00
Aug.	18.	By Check Mississippi Printing Co.	681 05
	30.	By Check Postmaster, Vicksburg	48 15
1911.			
Jan.	16.	By Check L. B. Sparkman, Treasurer	1,319 72
		Total	$2,887 65

Thus it will be seen that the retiring treasurer has placed in my hands the balance of $1,319.72, which constituted the assets of this Association on Jan. 16th. 1911.

RECEIPTS.

1911.			
Jan.	16.	To Balance from H. L. Sutherland	$1,319 72

DISBURSEMENTS.

March 20.	By Check Miss. Printing Co.	$ 486 80
April 8.	By balance on hand	832 92
		$1,319 72—$1,319 72
To balance on hand		$ 832 92

Respectfully submitted,
L. B. SPARKMAN,
Treasurer.

The chair appointed Councilor Ullman and Delegates Cook and Brongher an auditing committee.

Councilor Dye called up the amendments to the by-laws relating to medico-legal defense.

Councilor Ullman demanded roll-call at which the following additional members of the House were seated: Goyer of Chickasaw, Hughes of Coahoma, Little of Copiah, Cook of Forrest, Rowan of Harrison, Herbert of Hinds, Leathers of Lafayette, Reynolds of Lauderdale, McMillan of Lee, Sandifer of Leflore, Jones of Lincoln, Walley of Perry, Purser of Pike, Garraway of Rankin, Haralson of Scott, Catchings of Wilkinson.

Councilor Dye then read the amendments to by-laws proposed by a committee at Oxford, providing for a medico-legal defense fund, which on motion of Elliott of Marshall were adopted as read.

The nominating committee was then selected as follows: 1st. District, Hughes of Coahoma; 2nd. District, Elliott of Marshall; 3rd. District, McMillan of Lee; 4th. District, Boyd of Monroe; 5th. District, ———— ————; 6th. District, Willson of Warren; 7th. District, Reynolds of Lauderdale; 8th. District, Hosey of Clarke; 9th. District, Jones of Lincoln; 10th. District, Cook of Forrest.

On motion of Secretary Howard the courtesies of the House were extended to Dr. H. L. Sutherland of Rosedale for life.

On motion of Councilor Dye the House then adjourned to re-convene after the scientific exercises Wednesday afternoon.

Wednesday, April 12th. at 4:30 P. M. the following additions, and alterations, were made to the personnel of the House: Butler of Amite, Kendrick of Alcorn, Alexander of Tunica, Reed of Itawamba, Burnham of Jasper, Wynne of Bolivar, Rape of Jackson, Merritt of Tippah, Clay of Tallahatchie, Smith of Attala, Barnard of Sharkey, Locke replacing McCoy of Pearl River, Smith of Simpson, Moody of Prentiss, Beacham replacing

Purser of Pike, Smith of Covington, Towns replacing Lewis of Jefferson, Gaither replacing Leathers of Lafayette, Foster of Holmes, Ervin of Lowndes, Majure of Neshoba, Brown of Clay, Brown of Grenada, Arnold of Winston, Weeks of Choctaw, Taylor of Carroll, Batson of Greene, Perkins of Panola, Wynne of Tate, Meeks of Tishomingo, Burnham of Jasper, Ex-President Curry.

Dr. H. L. Sutherland spoke to the amendment to by-laws relating to the treasurer's bond offered by Secretary Howard at last meeting and on motion of Brown of Clay same was unanimously adopted.

President Young read a letter asking an endorsement of the American Tuberculosis Association and appointed Dr. Sutherland, Ex-President Curry and Delegate Catchings a committee to consider and report on same.

President Young read several letters and telegrams extending invitations from various towns for the 1912 meeting.

Dr. Sutherland moved the rescinding of that part of the Gulfport resolutions relating to the source of the five dollars to be paid for insurance examinations. On motion of Gaither of Lafayette this was tabled.

Secretary Howard offered an amendment to the by-laws as follows:

Chapter IV. Add section 4 as follows: "No paper by a member shall be listed on the official program unless its author's membership has been certified to the secretary of the Association by March 15th.

Delegate Cooper of Newton read report of the committee on secretary's report as follows:

To the House of Delegates of the Mississippi State Medical Association.

Gentlemen:—We, your committee on the secretary's report, find the communication from the American Medical Association regarding the proposed amendment which contemplates an enforced membership in the American Medical Association on the part of the members of all State Associations to be inadvisable and suggest that our delegates be instructed against this amendment.

We further suggest that the secretary include in the *Transactions* the Necrology Report as heretofore.

Respectfully submitted,
I. W. COOPER.
C. M. COKER.
C. D. MITCHELL.

On motion of Councilor Bullitt the report was adopted.

On motion of Councilor Eason the House then adjourned and reconvened at 7 A. M., April 13th.

At this meeting, in the absence of the president, Vice-President Boyd, holding a seat in the House as delegate from Monroe, occupied the chair.

Dr. Sutherland, on behalf of his committee, asked that the House endorse the American Tuberculosis Association, which was done.

Councilor Ullman presented the report of the auditing committee as follows:

To the House of Delegates Mississippi State Medical Assoeiation,
Jackson, Miss.

Gentlemen:—Your auditing eommittee wish to report that they have examined the books and accounts of the seeretary and of the treasurer and have found the same correct.

We have also examined and approved the following aecounts against the Assoeiation:

J. B. Bullitt	$ 28 10
J. S. Ullman	40
Mississippi Printing Company	130 15
Seeretary's expense aecount	22 46
S. E. Eason	5 75
M. C. Lilly & Co.	30 00
L. B. Sparkman, Treasurer	21 00
	$237 86

We wish to take this means of eommending the work of the seeretary during the year and the systematic way in whieh his aceounts are kept.

Respectfully submitted,
F. M. BROUGHER.
I. H. C. COOK.
J. S. ULLMAN, Chmn.

On motion of Councilor Coker the report was accepted and adopted and the committee discharged.

On motion of Secretary Howard the thanks of the Association were extended to Rev. A. F. Smith, Hon. A. C. Crowder, Mr. W. H. Watkins and the Jackson Sanatorium for courtesies extended during the meeting.

The amendment to the by-laws regarding date on which the membership of authors of papers must be certified was called up and passed.

The report of the Council was presented, as follows:

The Council met at 12 M. April 12th. Present: Drs. Williams, Ullman, Coker, Underwood, Eason, Dye and Bullitt.

The publieation by the press of the able presidential address of Dr. J. W. Young was unanimously authorized.

A charter was granted to the Alcorn County Medical Society (4th. District).

Tippah and Union Counties have surrendered their respective charters. A new charter was granted to the Tippah-Union Two-County Society.

A new county having been formed from portions of Perry and Green Counties, and Perry-Green Society having surrendered its charter, a new charter was granted to the new Perry-Green-George Tri-County Society.

Itawamba and Lee Counties (members of the Monroe-Chickasaw-Itawamba-Lee Four-County Society) were transferred from the 3rd. District to the 4th. District; and Choctaw County was transferred from the 4th. to the 3rd. District.

Calhoun County was transferred from the 2nd. to the 3rd. District and Benton County was transferred from the 3rd. to the 2nd. District.

DAN'L J. WILLIAMS, Chmn.
JAMES B. BULLITT, Sec'y.

The nominating commitee reported as follows:

JACKSON, MISS., April 13, 1911.

To the Council and House of Delegates.

Gentlemen:—We, the nominating committee, beg leave to submit the following nominees:

President: D. J. Williams, Ellisville; W. W. Reynolds, Meridian; W. C. Elliott, Holly Springs.

Vice-President: J. T. Longino, Jonestown; S. E. Eason, New Albany; J. C. McNair, Fayette.

Treasurer: L. B. Sparkman, Cleveland.

Councilors: 5th. District—C. M. Coker, Eden; 6th. District—S. W. Johnston, Vicksburg.

Delegate to A. M. A.: Principal—J. W. Young, Grenada; Alternate—C. D. Mitchell, Pontotoc.

State Board of Health: E. A. Clarke, Arcola; W. W. Mathis, Taylor; G. S. Bryan, Amory; John Darrington, Yazoo City; S. H. McLean, Jackson; J. M. Guthrie, Meridian; A. P. Hand, Shubuta; J. H. Johnson, Brookhaven; T. E. Ross, Hattiesburg; S. W. Glass, Dublin; I. W. Cooper, Newton; W. H. Rowan, Wiggins.

T. G. HUGHES,
W. C. ELLIOTT,
W. W. McMILLAN,
R. M. BOYD,
W. D. McCALIP,
T. F. WILLSON,
W. W. REYNOLDS,
J. T. HOSEY,
D. W. JONES,
I. H. C. COOK,
Nominating Committee.

Per T. G. HUGHES, Sec'y.

Dr. Rowan of Wiggins requested that his name be withdrawn from the list of nominees for the State Board of Health. This was done and the name of Dr. O. M. Turner of Jackson was substituted.

Dr. Reynolds of Meridian withdrew his name from the list

of nominees for president, stated that he was authorized to speak in similar terms for Dr. Elliott of Holly Springs, and moved that the secretary cast the vote of the House for Dr. Williams. On motion of Haralson of Scott this was passed by a rising vote.

Dr. Williams thanked the House and tendered his resignation as councilor of the 8th. District.

On motion of Booth of Sunflower the secretary cast the vote of the House for the nominating committee's nominees for vice-presidents, delegates to the A. M. A. and treasurer.

Herbert of Hinds nominated Dr. J. D. Gilleylen of Jackson for councilor of the 6th. District.

Roll call by counties was demanded by Jones of Lincoln which showed seventy-three votes in the House.

A vote taken for councilor of the 6th District. resulted as follows: Johnston 47; Gilleylen 26; and Dr. Johnston was declared elected.

On motion of Booth of Sunflower the secretary cast the vote of the House for A. M. Coker of Eden for councilor of the 5th. District.

Dr. G. W. Wallace of Arbo was nominated by Councilor Dye for councilor of the 8th. District and on motion of Jones of Lincoln the secretary cast the vote of the House for Dr. Wallace.

A ballot on the nominees for the State Board of Health was called. The chair ruled that no ballot should be counted unless it contained five names. The vote was as follows: Cheek, 43; Mathis, 11; Bryan, 43; Darrington, 47; McLean, 21; Guthrie, 10; Hand, 6; Johnson, 34; Ross, 37; Glass, 25; Cooper, 57; Turner 26. One vote was not counted, under the ruling of the chair as to the requirements of a ballot.

On motion of Curry of Lowndes Drs. Cheek, Bryan, Darrington, Ross and Cooper were declared unanimously elected.

Invitations for next meeting were extended from Vicksburg by Councilor Johnston and from Gulfport by Delegate Sheely.

On motion of Councilor Ullman Jackson was selected as the place for the 1912 meeting.

The House then adjourned.

E. F. Howard,
Secretary.

MISSISSIPPI MEDICAL MONTHLY.

E. F. HOWARD B.S., M.D., Editor and Publisher.

S. MYERS M.D., Business Manager.

ASSOCIATE EDITORS

B. B. MARTIN M.D., Vicksburg.
H. M. FOLKES M.D., Biloxi.
H. L. SUTHERLAND M.D., Rosedale.
M. H. BELL M.D., Vicksburg.

OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

The Association meeting of 1911 has now become one of the things of the past and as we look back upon it and compare it with those of former years we have every reason to be satisfied.

While the registration did not break the record set in 1909. it fell short by only nineteen and this, from the standpoint of attendance at the scientific sessions, was more than counterbalanced by the fact that at no time were there simultaneous meetings of the Association and House of Delegates, so that the delegates, for the first time in several years, were free to attend all the scientific sections. The result was manifest in the exceptional interest shown in the scientific work. Unfortunately several of the essayists were prevented from being present, but the discussions of the papers read were so general that it was with difficulty the program was finished on time.

The legislative body passed several amendments of considerable moment. Chief of these was that offered by Dr. J. W. Gray at Oxford in 1910, providing for a medico-legal defense and funds to maintain it. Incidentally this means that next year the per capita dues will be three dollars instead of two, probably the best investment that our members will make during the rest of their lives.

As is usual every fourth year, the chief interest in matters before the House of Delegates centered on the election of those members of the State Board of Health who are chosen by the Association and the selection of five of the old members was an endorsement, in the most unqualified terms, of the good work done by the Board during the past term, and especially in their efforts towards the promotion of public health and sanitation. The men chosen—Bryan, Darrington, Cheek, Cooper and Ross —have always stood for decency and progress and our affairs

are safe in their hands. We expect a great deal of the new Board and we venture the prediction that we are not going to be disappointed.

The choice of the new president, also, was eminently fitting. The editor of the *Monthly* well recalls his first meeting with Dr. Williams—as the doctor expressed it in a recent letter: "in the dark, on our way to the capitol to attend the first meeting of the House of Delegates; you and I were the only ones there." Since that first meeting seven years ago, as delegate, councilor and secretary of the Association, the writer has been to every meeting and has always found Dr. Williams on hand, doing thoroughly and well whatever duty was imposed upon him. His service as chairman of the council was of infinite benefit to the Association and his rulings, when called on to untangle some knotty problem, have been invariably sane and fair. No other member has been of such assistance to the secretary of the Association who has freely applied to him, on numerous occasions, and never known him to fail to "deliver the goods".

SOCIETY OF TROPICAL MEDICINE.

New Orleans, La., April 10th. 1911.

Officers and Members Mississippi State Medical Association.

Gentlemen:—

The Committee of Arrangements in New Orleans extend to your society and your officers an invitation to attend a session of the American Society of Tropical Medicine in New Orleans on May 18th. and 19th. 1911.

The Arrangement Committee would appreciate it if those wishing to attend would notify the Secretary, Dr. J. B. Guthrie, 602 Perrin Building, New Orleans, La.

The committee would be glad to make reservations for any one of the Association desiring to attend and would appreciate it if you would give this letter publicity in your official journal.

Very respectfully,

J. B. Guthrie M.D.,

Chairman Committee of Arrangements.

Indiana has recently passed a "law for the prevention of blindness due to ophthalmia neonatorium", which provides for the reporting of all births on blank forms which contain, in addition to other data, the query "Were precautions taken against ophthalmia neonatorium?" and rendering charges for professional services unlawful unless the report is made.

Society Proceedings.

East Mississippi Four County Medical Society met in Amory the third Tuesday in March, in the offices of Drs. Bryan and Burdine, Dr. Elkin in the chair. Dr. W. H. Rowan was present and elected to honorary membership. Several interesting clinics were presented by Drs. Bryan, Burdine, Farrar, Sloan and others; at least a dozen clinical cases were brought forth. Amory physicians furnish the best clinics of the circuit. We meet at Tupelo, Aberdeen, Houston and Amory and we invariably have a fine clinic at Amory. Dr. Will Coleman of Aberdeen read a good paper: "Varicose Veins Of Leg Complicated By Ulcers." Discussion was full and free by Drs. Burdine, Rowan, Bryan and Leathers. Dr. Leathers gave his lecture at the opera house at 8 P. M. to a packed house, this being Amory's open meeting for the year. The next meeting will be held at Tupelo on the third Tuesday in April. Dr. Marcus Haase of Memphis will be with us there and discuss 606 freely. He will have some of his patients with him to whom he has administered 606.

F. J. Underwood.

Personals.

Dr. Sydney W. Johnston, surgeon of the Mississippi State Charity Hospital at Vicksburg and councilor of the 8th. District for many years, is seriously ill in New Orleans, the result of infection of a finger. He is under the care of Professor Matas, and his many friends hope for a speedy recovery.

Dr. David Max Henning, one of the best known surgeons of Memphis, was married on April 25th. to Miss Charlie Scott, daughter of the Hon. Chas. Scott, at Rosedale, Miss. The very many friends of Dr. Henning in Mississippi will unite in wishing him and his bride a life full of happiness and prosperity.

Book Reviews.

STATE BOARD QUESTIONS AND ANSWERS. By R. Max Goepp M.D., Professor of Clinical Medicine at the Philadelphia Polyclinic. Second Edition Revised. Octavo volume of 715 pages. W. B. Saunders Company, Philadelphia and London. 1911, Cloth, $4.00 net; Half Morocco, $5.50 net.

In these days when examinations for license to practice medicine are so unpractical, and usually so absolutely far from

testing the ability only the memory of the applicant, this work of Professor Goepp will fill a great need among the students of medicine who desire to pass the various State Boards and who need a quick review of the subjects studied in the earlier part of the course. For such, it will be invaluable and may prevent many a good man from failing to pass simply because he had not framed his answer according to the lights of the barn yard examining board. The material for the volume, selected from the State Board examination questions running over many years, in which many repetitions of the question varying only in form occurred, is necessarily very much condensed and the writer must confess to pleasure in reading the questions and answers, a general and rapid review of all the branches of medicine, inorganic, organic and physiologic chemistry, anatomy, physiology, pathology, bacteriology, materia medica and therapeutics, practice, surgery, obstetrics, gynecology and hygiene, which many of us can take without serious injury.

MYERS.

INTERNATIONAL CLINICS. A Quarterly Of Illustrated Clinical Lectures And Especially Prepared Articles. Edited by H. W. Cottell A.M., M.D., Philadelphia. Vol. I, Series 21, 1911. J. B. Lippincott Co., Philadelphia and London.

This volume contains articles on the spread of pellagra and the treatment of syphilis with 606 and investigations of polio-myelitis that are very timely. Others on the development and tecnic of sphygmomanometry and the value of blood-pressure estimation in internal medicine will, if carefully read, prove convincing arguments to many who are not accustomed to use this valuable aid in diagnosis. An article on modern infant feeding by Ostheimer of the University of Pennsylvana, good enough in its way, occupies several pages that in a book of this character could be used much more advantageously in the discussion of something more in line with the scope of the work. But the gem of the collection is Montgomery's article on the cellular basis of the determination of sex, and we are inclined to wonder how it strayed into what was formerly our meatiest clinical publication. There has been a tendency of late to too much of this sort of thing in the clinics for limitation of space usually prevents the author from doing justice to his subject and the readers, who as a rule prefer the clinical articles, pass it up unread.

HOWARD.

To The Profession:

Complying with numerous requests, we have decided to receive in our institution, in detached buildings, mental cases, and drug and alcohol addicts.

We wish to call your attention to our exceptional facilities for caring for these classes of cases.

To begin with, our location right on the beach of the Gulf of Mexico, with its drowsy and soothing atmosphere, gives us an advantage possessed by no other institution in this country. In the next place, we have the most csmplete system of baths in the South. Our bath and treatment departments are in the hands of a skilled masseur.

Our Superintendent, Dr. W. R. Card, has had six years experience in one of the largest institutions in the country in handling these patients.

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MISSISSIPPI MEDICAL MONTHLY

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*SOME INTESTINAL PARASITES OF NORTH MISSISSIPPI.

LOUIS KOHLHEIM M.D.,

GUNTOWN.

In the course of a general practice of more than four years in the counties of Lee, Prentiss and Union I have encountered three hundred and twenty-seven cases of intestinal parasites as follows:

Necator Americana or hookworm.....269
Ascaris lumbricoides or roundworm..... 21
Oxyuris vermicularis or pinworm..... 15
Strongyloides intestinalis or Cochin China diarrhoeaworm.. 5
Hymenolepis nana or dwarf tapeworm..... 17

Twelve of the hookworm cases were associated with other parasites.

These figures are in no sense statistical. They show merely the relative frequency with which these worms have been met in the practice of an individual worker in northern Mississippi. They show, for instance, that this section of the state is heavily infected with "Stiles' disease", and that ascaris, for which all of our mothers used to worm us regularly, is comparatively rare.

Only two of my hookworm cases were colored patients, although I have examined the feces of one hundred of our native negroes for the purpose of determining the extent to which they are acting as carriers in my neighborhood.

In addition to the helmanthese enumerated above I have also demonstrated the presence of amoebic dysentery in this portion of the state.

The entomologists have taught us that it is necessary to know the life history of insect pests in order to protect against their ravages and this is equally true in regard to disease-producing parasites that afflict mankind.

Fortunately worms are comparatively easy to study and the life history of those mentioned in this paper have been worked out, so that in the light of present knowledge prophylaxis is so simple as to appear almost ridiculous.

*Read before the Mississippi State Medical Association, 1911

Loor, Claude Smith, Bass and others have demonstrated that hookworm infection almost invariably takes place from soil polluted with human feces containing larvae. Bass says: "The worms penetrate the skin chiefly through the hair follicles and sweat pores, enter the blood stream, pass through the right heart to the lungs, into the bronchi, thence to the mouth and are swallowed, pass through the stomach to the small intestine where they attach themselves to the mucus membrane and develop to adult life."

The diagnosis of hookworm infection is made by finding the ova in the feces by means of the microscope. The physical signs that would cause one to suspect the presence of an infection, such as hookworm eye, hookworm heart, etc., are after all but the signs of an anemia and all cases of anemia are not the product of hookworm infection, at least not in Mississippi.

For my section of the state I can speak from first hand knowledge of the situation, and from what I have seen I am thoroughly convinced that instead of being a medical curiosity the hookworm is producing more deaths, directly and indirectly, and causing more poverty and wretchedness and inefficiency than any other malign influence in operation there to-day. The hookworm undoubtedly gives rise to a moral degeneration in full keeping with the physical degeneration of its victims. Does the poison generated by this parasite act on the system like some terrible drug such as morphine or cocaine, or does the victim, feeling that he is incapacitated, begin making excuses and form the habit of being economical with the truth? Everybody knows that nine out of every ten excuses are lies.

The ascaris lumbricoides very much resembles the ordinary earthworm, but is more grayish and red. Dr. Stitt describes the male as being from five to eight inches in length and the female from seven to fifteen inches long. He says: "The ova are very characteristic, with a rough mammillated exterior. This at times is shelled off and we have a smooth egg which may be mistaken for eggs of other parasites. The eggs leave the body in the feces and after a long time—a few weeks to several months, according to temperature, develop an embryo which remains in the shell until swallowed by some man or animal."

It is stated that they will remain alive for years. On being swallowed the embryo leaves the egg and we have males and females developing in the intestine.

Like all other intestinal worms, the lumbricoides give rise to no characteristic symptoms by which a diagnosis of their presence can be made. This is an important point to remember,

for of all the substances used as an anthelmintic santonin is perhaps the most dangerous.

Potter, in his materia medica, states that two grains killed a delicate child five years old.

I myself had the misfortune to witness the death, from its effects, of a little girl aged eight years. I do not know the quantity of the drug used. It was administered by the child's aunt who made a diagnosis of worms because the little girl had laughed in her sleep. A post mortem was refused. No worm was passed before death. However, I secured an ample specimen of feces. A most painstaking search, to which I devoted several hours, failed to reveal an ovum of any kind.

Stitt says of the oxyuris vermicularis, alias pinworm, alias seatworm, alias threadworm, that "the male is about one-sixteenth of an inch long, and the female a little less than one-half an inch in length."

The eggs are thin-shelled, plano-convex, and show a coiled-up embryo. After the eggs are swallowed the adults develop in the small intestine where mating takes place, the males then die. The fertilized females go to the coecum and colon where they remain until they reach maturity. At this time the females wander to the rectum where they either expel their ova or themselves, working their way out of the anus. This usually occurs at night and scratching induced by the itching causes the eggs to be widely spread about the parts. The worms may also wander into the vagina, urethra or under the prepuce. It will be seen as a result of the scratching the fingers become contaminated with ova which may be carried to the mouth and so cause fresh infection.

The treatment for this parasite, given in many text-books, frequently fails. The reason is readily seen by remembering the life history, the early location in the small intestine and later in the large. Give santonin for the young adults in the small intestine and enemata for the gravid females in the rectum. Lime-water is excellent for the latter purpose.

Strongyloides intestinalis, formerly thought to be the cause of cochin-china diarrhoea, reproduces by parthenogenesis. There are two generations: first, the parasitical or intestinal form; second, the free living or fecal form. The intestinal form is represented only by females. These are about one-half of an inch long. Their eggs ordinarily hatch in the intestines and when the infection is severe the "rhabditiform embryos" can be found in the feces in great numbers. The ova never appear in the feces except during purgation or an active diarrhoea. They very much resemble hookworm eggs from which they are dif-

ferentiated by being accompanied by the embryos and the fact that they measure about ten microns less in each diameter.

Outside the body the rhabditiform embryos develop into the free living or fecal form. Here then are males and females which after mating produce rhabditiform larvae which later change to filariform ovas. These being swallowed in water or otherwise again start up the parasitical generation.

Hymenolepsis nana is the smallest of the human tapeworms. It is from one-fourth to one-half-inch in length and less than one-twenty-fifth of an inch in breadth. The eggs are quite characteristic of the species. Most of my patients looked like hookworm victims, due to the anemia.

Although this worm is very small the number present may be very large, running into the thousands. A form found in rats which is thought to be identical with this worm does not require an intermediate host and is also capable of reproducing succeeding generations in the intestine. Infection takes place by swallowing the eggs.

From the foregoing resume of the life histories of these several intestinal parasites it will be seen that the prophylaxis is simplicity itself. "Stop polluting the soil" very nearly says the last word. The practical difficulties, however, in attaining this end are great. Our people will first have to be instructed and educated in this important matter. I would suggest as a "starter" that every pressure be brought to bear on the proper authorities to have every school in the state equipped with sanitary closets. Not only will this accomplish great good in checking the spread of infection among school children, and in introducing information on the subject into the homes where the children live, but will serve a greater purpose as an ever-present object lesson to the now growing generation of our citizens

In removing foci of infection let us keep in mind the advantage of medication, as well as sanitation and education. I have had to treat a large number of my hookworm patients gratuitously. Those needing treatment most are generally poor and ignorant and much diplomacy is required in dealing with them, but when the confidence of one of this class is gained he generally becomes a powerful factor in his little circle in inducing others to be examined and treated, thus unconsciously becoming a worker in a useful cause.

In closing I desire to earnestly urge upon you never, under any circumstances, to yield to the temptation to treat a patient for "worms" until after the diagnosis has been positively made.

The different parasites require radically different treatment. No matter how plain the case may appear to be, re-

member that there is every chance to be mistaken. Let no man persuade you that he can make a diagnosis by simply inspecting the patient. His position is not tenable.

Notwithstanding the tremendous importance of this subject, if all other portions of the state are like my own there is not more than one physician to every twenty thousand of population giving any serious attention to intestinal parasites in Mississippi. The eradication of the hookworm should not only appeal to our medical sense but to our patriotism.

When I look about me as I journey along country roads and through villages and on every hand see hopelessness and helplessness written on the anemic faces of men, women and children, it is a source of pride to reflect that I am an humble representative of a noble calling into whose hands it has been given not only to lift those already smitten from their pitiable condition, but to so arrange that there need never be another case among succeeding generations of our fellows.

Let us go back home and do something.

Away over somewhere in the Book of Joel we read: "And I will restore to you the years that the locust hath eaten, the cankerworm, and the caterpillar and the palmerworm, my great army which I sent among you."

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*A REPORT OF TWO CASES.

I. W. COOPER M.D.,

NEWTON.

I. Baby B; was born August 26th. 1907, after a normal labor. On the second day a slight redness of the conjunctivae was noticed, and on the day following a violent blennorrhea of both eyes had developed. A gonorrhoeal infection was immediately suspected, but I was completely in the dark as to the source of the infection as the mother was absolutely above suspicion and the father was regarded as a man of strict moral life. But all the evidences of an ophthalmia neonatorum were present and treatment was begun for this condition.

Three drops of a fifteen per cent. argyrol solution were dropped in each eye every three hours. Once a day one drop of a one per cent. solution of atropine was put in each eye. Every thirty minutes day and night the pus was cleaned out with a boric acid solution. Ice cloths were constantly applied.

*Read before the Mississippi State Medical Association, 1911.

In spite of these measures the inflammation was of a virulent type and every indication was that blindness would result.

During the first six days the father was not at home and I was considerably worried as to the source of the eye trouble as the mother's recovery was uneventful and at no time did she show the slightest sign of an infection. On the seventh day the father returned and before going home he, being entirely ignorant of the baby's condition, came to my office for treatment of a well developed case of gonorrhoea. On inquiry I found that he had had intercourse with his wife two days before parturition and illicit intercourse eight days before intercourse with his wife. At the time of the intercourse with his wife he had no signs of any trouble except a slight itching to which he attached no importance.

The treatment as outlined above, with slight variations, was continued, the inflammation ran a violent course for two weeks when it subsided rapidly and fortunately the child has no signs of the former trouble.

II. A. B., female, aged seven, was brought to me for some trouble with the right eye. As far as the mother knew the family history was negative, as was also the personal history up to the time the eye became affected.

On examination there was found flat nose, cicatrices at angles of mouth, square forehead and the classical teeth of Hutchinson. A marked anemia and all signs of inherited syphilis were present. The conjunctiva was congested and a corneal opacity was clearly seen.

The case was referred to Dr. J. M. Guthrie of Meridian and I am indebted to him for the following:

"The patient had been suffering with her right eye for two weeks. On examination there was found ciliary injection, lacrimation, ground glass opacity of the cornea, beginning in the center of the deep layers of the true cornea and spreading towards periphery. Photophobia was marked and vision was so interfered with that she could only count fingers at three feet and there was very little more than light perception."

The diagnosis was syphilitic keratitis as inherited syphilis is responsible for more than fifty per cent. of all cases of diffuse interstitial keratitis. It usually appears at the time of second dentition and is more frequent in females.

Dr. Guthrie suggested the following line of treatment which was followed by me: Three times a day, one drop of a one per cent. solution of atropine was dropped in eye, the eye was protected from light by colored glasses and washed with a boric acid solution. Large doses of mercury were given, plenty of fresh air and a nutritious diet were ordered. The acute symp-

toms began to subside after six weeks, then yellow oxide of mercury was used locally to clear the opacity which nearly covered the entire cornea.

In a short time the left eye became involved and the same local treatment was used, but instead of the mercury the patient was given the iodide of potassium in ascending doses until in three weeks time she was taking an hundred and twenty grains a day. The acute involvement of the left eye lasted only three weeks.

Five months have elapsed since the last acute symptoms were manifest, the cornea having cleared wonderfully and from present indications the child will have fair vision.

The lesson learned by me from the foregoing cases are posscssed of the utmost importance to the profession. I learned first that I was exceedingly derelict in my duty in not using the prophylactic treatment of ophthalmia neonatorum. This treatment should be used in every instance and the supposed high moral character and standing of the parents should not be allowed to delude us into a feeling of safety. Laymen need education as to the serious consequences of a case of gonorrhoea. Ignorance as to gonorrhoea is much greater and far more extensive than ignorance of syphilis. The awfulness of syphilis is apparent to the eye, but in gonorrhoea experience alone teaches its consequences.

Legislation in some states has already reflected the other lesson and that is that an examination of the contracting parties to a marriage should be made. True it is that this is opposed to the sentimental but in its actual operation and in the long run its effects would be exceedingly beneficial. The objects to be attained far outweigh in point of importance the outrage committed on sentimentalism.

These lessons should be burned into the minds of every well-thinking man, impressing him with the seriousness of the problem which they present. The burden of urging an immediate solution of the problems rests upon the medical profession. For the knowledge of the causes and the instances is with us and with us alone and we must carry that knowledge locked within our bosoms. The awful picture presented by a child foredoomed to a life of suffering, or to a life wherein opportunities are necessarily limited and hopes blasted even as they rise, beggars description. The only real happiness in life to most of us and certainly to the average man is the pursuit of the object of his ambition. How must it be to one who is defeated before the race is run and through no fault of his own. The solution of the problems carries with it a train of results which when comprehended causes us to feel that an under-

taking of this solution is imperative and should be our delight. With sentiment aroused to support it, it is simple. We owe it to ourselves and to our country to undertake the solution of this problem. Education is the first necessity in this as in most of the campaigns waged by us against disease. Education precedes legislation and upon legislation we must in a measure depend. With this problem solved, a monument more enduring than one of marble will ever testify to our keen sense of our obligations to our fellow man. Healthy men and women, who at least have had a fair share of the opportunities of life will walk and laugh where before anemics have crept and sighed. This, gentlemen, is an obligation we should recognize and manfully meet.

*A FORGOTTEN USE OF CALOMEL.

S. MYERS M.D.,

VICKSBURG.

One of the curious facts in medicine is that tendency of medical minds to follow blindly their leaders and teachers, and nowhere is this tendency better exemplified than in the domain of therapeutics. Drugs introduced by leaders have their rise and then fall, never to be heard of again. Naturally, in the crowd of drugs thus forgotten, some valuable drug or some valuable action of an important drug is consigned to oblivion when the race for something new has stirred the leaders to explore some new field. Therefore I have no apology to make in endeavoring to recall to your minds an action of calomel, one of the most used and reliable of drugs, which although known once and then forgotten was rediscovered by Jendrassik in 1866 and is now in a fair way to be forgotten again. A study of the latest editions (1910 and '11) of the text-books upon Practice by such eminent teachers as Tyson, Osler, Anders, the new work on Practice by Musser and Kelly, Osler's "System of Practice"; in none of these do we find one reference to this simple and reliable drug action, but all refer to the barbarous Southey's tubes which are painful to insert and exceedingly liable to allow the tissues, in their condition of lowered vitality due to overstretching from the dropsy, to become infected with erysipelas. H. C. Wood in his "Therapeutics" mentions the method, praising its value in chronic parenchymatous nephritis and cardiac dropsy, as does Sollmann on page 684 of his invaluable Text-book on Pharmacology. I refer to its diuretic

*Read before the Mississippi State Medical Association, 1911.

action, not as used in the form of Niemeyer's pill, the one grain each of calomel, squill and digitalis, but in the administration of massive doses of calomel to provoke diuresis. When the vegetable salts of potassium have failed, when caffeine, digitalis, diuretin, theobromine, etc., give no results in either cardiac or renal dropsy, calomel given according to the method of Jendrassik will invariably astonish and delight the practitioner by the rapidity and completeness of its action.

Sollmann says it is more effective in cardiac than in renal dropsies, but in a somewhat wide experience I have not been able to note any difference. The method consists of the administration of from one-half to one drachm of calomel in five grain doses every two hours, following this at least with several salines in order to remove any calomel remaining from the intestinal tract. While occasionally beneficial in hepatic ascites, it has no action in pleuritic exudates, nor in provoking diuresis in healthy individuals. While of course different observers have obtained varying results, Schild, in 1892 (See Sollmann) reported three cases in which an actual lessened per cent. of albumen occurred. According to H. C. Wood, it is the first effect of the calomel which causes the diuresis; other authorities state that the mechanism of its action is unknown. It may be remarked that calomel used in this manner rarely produces purgation and never does salivation occur.

In order to exemplify this action of calomel, let me quote the following case: C. G. M. had been a sufferer from chronic parenchymatous nephritis for eight or nine years; had returned from a three months' stay at Hot Springs, October 3rd. 1909; when first seen she was oedematous from feet to hips, abdomen was swollen, urgent dyspnoea; patient unable to sleep except upright in a chair; she had been taking cream of tartar *ad lib.* with no benefit resulting, so was put upon infusion of digitalis with caffeine. After one week's trial, no benefit resulting, she was given two drams of calomel in five grain doses every two hours, with the result that according to the measurements of the trained nurse in attendance, in two days she passed four gallons of fluid, she herself saying "she felt like a crust was breaking and the fluid pouring out", her dyspnoea was gone, she was able to sleep comfortably in the bed and the picture was changed from that of an absolutely miserable woman to one of comparative comfort. The patient afterwards was put upon a tonic treatment and while her urine continued to have a large amount of albumen and dark granular casts, she was more comfortable than she had been for a year, and had no return of the oedema for several months, when a repetition of the treatment again removed the dropsy.

It is all the more remarkable that this beneficent action of a drug, in daily use by every practitioner of medicine, should be so entirely overlooked, and it is with the hope of awakening interest in its use by the method of Jendrassik that these few notes are presented.

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*OYSTERS AND TYPHOID FEVER.

H. S. CAPPS M.D.,

GULFPORT.

While at no time in recent years has there been an actual epidemic of typhoid fever in this section of the country, still we cannot deny the fact that there is a continual outcropping of sporadic cases of this disease in Gulfport and at other points along the coast. Our records of contagious and infectious diseases, filed in the offices of our boards of health every month, are not complete without a few cases of typhoid fever, and too often the undertaker comes with his certificate of death from the same disease.

This continued appearance of cases of typhoid along the coast, in a section of the country which has been otherwise exceedingly healthy, should lead us to an investigation of the cause. Three things have been blamed for the cases of typhoid that we have had in Gulfport, namely, water, milk and oysters. I do not believe, however, that in an investigation of this character we should by any means leave out the unsanitary condition of privies, cesspools and alleys, nor the deadly work of the ever-present dirty little fly.

As a matter of fact all the great epidemics of typhoid fever recorded in history are traced to an impure water supply which has been contaminated by a sewer or privy. This was the case with the epidemics at Luzerne, Switzerland, at Plymouth, Pa., and at Cornell University, Ithica, N. Y. I freely admit, however, that it may be transmitted in other ways, especially in sporadic cases where there is no epidemic.

It is a fact also that in most large cities of this country the typhoid fever death-rate is taken as an index of the purity of the water supply, and any marked improvement in one will almost certainly be followed by a reduction in the other.

In our case, however, I seriously doubt if the water supply has anything to do with it. Our water supply at Gulfport is obtained from artesian wells over eight hundred feet deep and

*Read before the Harrison County Medical Society.

furnished directly to residences through the mains. In other words we are using deep-well water, which stands at the head of the list of pure waters, there being only two classes of waters to compare with it—spring water and unpolluted mountain streams. Furthermore, if our cases of typhoid fever were due to an impure water supply we would probably have had a serious epidemic instead of a few isolated cases which we now have.

It is well known that in New York and Baltimore certain reefs of oyster-beds have recently been condemned on account of typhoid fever which was supposed to have been traced to them. In view of the fact that the catching and canning of oysters form one of the chief industries of this section, and also because some complaint has been made to me of oysters being caught out of the anchorage basin and near the sewers of Gulfport, I decided to have an ordinance passed prohibiting the catching and selling of oysters from the basin and near the sewers of this city.

Before passing this ordinance, however, as city health officer, I decided to make some investigations of my own, so that I could act intelligently.

Accordingly, on January 26th. 1911, I had three samples of oysters taken, one from the basin, one about a quarter of a mile and one about half a mile from the basin, and marked them DuVal, Showers and Bonansinga, respectively. I immediately sent these oysters to the state bacteriologist at Jackson, with a request to examine carefully for any contamination, and especially for typhoid bacilli. To understand the condition fully it is necessary to remember that the city sewers empty, one in the basin and one at the end of the pier.

The examination proved that each set of oysters contained the colon bacilli, the normal bacteria of the intestinal tract of men and many animals. The presence of typhoid bacilli itself was not demonstrated, although many tests were made for this purpose. In the examination of oysters, Dr. Wood says that he considered it best to examine the liquor, as this is more apt to contain contaminating bacilli than the internal organs of the oyster. (See Mass. State Board of Health Report, 1905.)

The report says that "the isolation, identification and differentiation of the typhoid bacilli being possible only through the greatest difficulty and precision, is rarely accomplished by bacteriologists; and the identification of the colon bacilli is generally accepted as the indicator of pollution. In any sewage containing typhoid bacilli there are many thousand times more colon bacilli, and the latter are more readily found.

"Colon bacilli themselves are comparatively harmless to man, yet their presence is indicative of the probable presence of the typhoid bacilli, as the sewage will contain with them the typhoid germ unless the most rigid rules of sterilizing excretae are enforced."

In the identification of the colon bacilli and search for the typhoid bacilli in these samples, Dr. Wood said that "the technique of the leading bacteriologists was adopted, modified and extended. Cultivation in lactose broth, liquefaction on neutral gelatin, plating in agar, identification of motility and morphology, and the formation of indol, gas and acid," were the methods he pursued. On making repeated tests of these samples of oysters from DuVal, Showers and Bonansinga beds respectively, all samples showed the presence of colon bacilli. The colon infection of the Bonansinga bed of oysters was apparently much less than in the other two sets named. As a matter of fact, the Bonansinga bed was farther away from the basin than the other two and was consequently less contaminated. This proves the value of Dr. Wood's examination, as he was not informed as to the relative distances of these beds from the sewers.

"The above named tests," says Dr. Wood, "were supplemented by Stokes' and Hiss' and Praetti media, with trials for the agglutinability by immune typhoid serum as a means of positively identifying the typhoid bacilli. These tests were repeated many times and although suspicious growths and one suspicious clumping by the serum were obtained," he is not positive that the presence of actual typhoid bacilli was proven. The test showed, however, the undoubted infection of the oysters by intestinal bacteria and their possible connection with typhoid fever.

This report of Dr. Wood is corroborated by the report of Dr. Petersen, city bacteriologist of Mobile, who was employed by Dr. LeBaron last year to make a study of the typhoid fever conditions in Gulfport at that time. In his report Dr. Petersen declared the oysters near the basin infected with colon bacilli. (See Dr. Petersen's report on milk, water and oysters of Gulfport, 1910.) It is true, however, that the typhoid bacilli will not live very long in salt water, as the chlorine liberated by sea water is deadly to the typhoid as well as many other germs. It is plain, therefore, that the safety of oysters as a food depends on their distance from shore and sewers, and also upon the depth of water in which they are bedded, as well as upon the proper care in handling them.

It must be remembered also that oysters may become infected after they are taken from the water, either by ex-

posure in some filthy shop or by dirty and careless handling of the shuckers; and I believe that they also become contaminated by a process of decay where they are kept out of the water for too long a time.

Our investigation so far leads us to the following conclusions: (1) Oysters taken from deep water, or from a considerable distance from shore or any infected point, are reasonably safe, provided they are handled carefully and are fresh. (2) On the other hand, those taken from shallow water near sewers or other infected points are probably contaminated and are unfit for human food, and their use should be prohibited by law.

Mississippi State Medical Association.

To the Physicians of Mississippi:

The enclosed is, in brief, what the Medical Association will ask from the next legislature.

Two years ago we failed in all we asked—chiefly from inertia on the part of our own members. Many of them did not know what we were asking.

To obviate a repetition of this state of affairs is the object of this letter.

You are earnestly asked, each one of you, to place these measures before the people of your community and endeavor to so arrange matters that no man who will not agree beforehand to support them be elected to the legislature from your county.

Fraternally yours,

D. J. Williams,
President.

Attest:

E. F. Howard, Secretary.

Measures advocated by the Mississippi State Medical Association, to be presented to the next legislature for enactment:

MEDICAL PRACTICE ACT.

To amend the present medical practice act so as to require all persons desiring to obtain license to practice medicine in the State of Mississippi to present a diploma from a reputable school of medicine whose course of study shall consist of not less than four years' work, of at least thirty-two weeks' work in each year, and whose entrance requirements shall be at least

a diploma from a Mississippi High School affiliated with the University of Mississippi, or its equivalent.

VITAL STATISTICS.

A bill on vital statistics, providing for the registration of births and deaths in each county, by a report in each instance to be made by the physician, midwife, nurse, or head of the family, and to fix penalties for failure to comply with this law.

LARGER APPROPRIATION FOR THE STATE BOARD OF HEALTH.

Realizing the necessity of a continuous campaign of education in public health, to lessen the great financial loss, the suffering and unnecessary loss of life caused by preventable diseases, this Association urges an annual appropriation of not less than twenty-five thousand dollars for the State Board of Health.

We earnestly believe that the good work done in the past few months by the State Board of Health should be actively continued. This renders the appropriation imperative.

D. J. WILLIAMS,
President.

Attest:
E. F. HOWARD, Secretary.

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MISSISSIPPI MEDICAL MONTHLY.

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S. MYERS M.D., Business Manager.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

On another page we reproduce the circular that has been recently mailed to all members of the State Medical Association and we earnestly commend it to the consideration of the physicians of the state.

At the last session of the legislature we offered bills to amend the medical practice act, to license midwives, to provide a simple beginning for the keeping of vital statistics, and to punish the crime of abortion. The proposed amendments to the practice act were so altered in the senate that, had they become law, we would have been in a worse fix than now; but fortunately some of our workers, headed by Dr. D. W. Jones of Brookhaven, persuaded the senators to kill the bill entirely rather than pass anything so horrible as the amendments made it. To the credit of the senators be it said that, as soon as the offensive features were pointed out, they recognized the inadvisability of such legislation. Our other bills slept peacefully in the pigeon-holes in the committee room throughout the session.

Now, the great reason this state of affairs existed was on account of the inertia of our members. Few knew what was going on, and of those few the number who exerted themselves was pitiably small. But if Dr. Jones and two helpers could put the offensive practice-act-bill, that had already passed the senate, on reconsideration and then kill it in one afternoon, what could not have been accomplished had all our members shown the same energy?

Now you know about these things. Come, let's all help get them.

Taking up the schedule of proposed legislation, let us see what it amounts to. In the first place it provides that only

graduates shall be licensed, and that the school of medicine graduating them must have as an entrance requirement a high-school diploma or its equivalent, and teach a four-year course. Can there be any objection to that? "Lives there a man with soul so dead" who will contend that a physician can obtain proper mental equipment in less than four years, or that one whose preliminary education is not the equivalent of that attested by a high-school diploma, which is generally attained at about seventeen years of age, can absorb the information offered at a medical college? The writer began the study of medicine at the age of twenty, having previously obtained the bachelor's degree in science from one of our best-known Southern universities. He graduated from the medical college most widely and favorably known in the entire South, and was third of the five "special-mention" men in a class of nearly a hundred—and he often wishes that circumstances had permitted more extensive study before he began the practice of his profession. We speak only of the beginning of the work, for of course no physician ever ceases his professional studies.

The second item on the list is a bill providing for vital statistics. To any one who may ask, "Why vital statistics?" we refer to Dr. Gray's paper read at the Oxford meeting of the Association: "The birth and lineage of Farmer Smith's Jersey bull is more easily proven under Mississippi laws than your own ancestry." Let the doubting Thomases, who are willing to be convinced, turn to the 1910 *Transactions* and read the paper for themselves.

The final item is a request for more money for the Board of Health. Does anyone deny they need it badly? Does any one condemn them for not having done more than they have—without money? Does not everyone, on the other hand, wonder how they have ever been anything more than an examining board on the niggardly allowance on which they have been operating for the past several years?

Honest, brother, down in the bottom of your heart aren't you ashamed for your state that these things haven't been remedied long ago? We are not afraid of the answer—don't need any—so we ask another question: won't you wake up and do the small thing asked of you in the circular letter, so that we may remedy matters? You may not think you have any "pull," but your apparent inertia will be an argument that may lose a vote and so kill these bills.

The Monthly is in receipt of the last report of the Director of the Cincinnati Sanitarium, which is well worthy of study and will repay the attention bestowed upon it.

Obituary.

Dr. Geo. H. Peets was born at Laurel Hill, La., in September 1837, and died at his country home, "The Valley," in the western part of Wilkinson county, May 4th. 1911, of rectal cancer. He received his literary training at the University of Virginia and his medical at the University of Pennsylvania, graduating from the latter in 1869. In 1861 he enlisted in Co. E, 21st. Miss., and was made second lieutenant, but later was relieved and made chief surgeon of Barksdale's brigade, in which capacity he served until the close of the war, also being in attendance on General Humphreys when he was wounded. At one time he had extensive planting interests and was quite wealthy. Later he re-entered practice. He was a power in his county in the seventies and eighties, during reconstruction days, and was one time representative from his county. He was three times married and leaves a large family. His third wife died only one year ago. He was a member in good standing of Wilkinson County Medical Society and up to one year ago was a member of the Mississippi State Medical Association.

Society Proceedings.

East Mississippi Four County Medical Society met at Tupelo, Tuesday, April 18th., Dr. Elkin in the chair and Dr. J. O. Gurney acting secretary *pro tem.* Several visitors being present, they were extended the courtesies of the floor.

Dr. G. S. Bryan presented a clinical case which was of considerable interest. Diagnosis Cholecystitis.

Dr. C. B. McCown presented a clinic on locomotor ataxia.

Dr. Hasse of Memphis had given this case two doses of salvarsan (intramuscular) with some improvement of symptoms. Dr. Haase discussed the case on account of being uncertain as to lues, and gave a talk on the origin of and indications for salvarsan, and he discussed the technique of giving intra-muscular and intravenous doses and their reactions. All present manifested great interest and asked numerous questions.

A motion prevaile* that a vote of thanks be extended Dr. Haase for his most excellent discourse.

Dr. L. C. Feemster read a paper on "Uncinaria." Discussed by Drs. Burdine and Bryan.

* Which appears in this issue.

Members present: Elkin, Bonner, Keyes, Bryan, Burdine, Green, Tubb, Spencer, McCown, Anderson, McMillan, Carruth, Boggan, Banks and Feemster. Visitors: Drs. Hasse of Memphis, Brown and Stone of Tupelo. F. J. Underwood.

Harrison County Medical Society met at Gulfport May 9th. 1911, Dr. C. A. Sheely in the chair. Present, Drs. Sheely, Parker, Mohler, Hood, Welch and Capps. Dr. Capps read a very interesting paper on "Oysters and Typhoid Fever,"* giving an account of some recent research work in which he had had examined oysters taken from near the mouth of the sewer at Gulfport.

The application of Dr. G. C. McGowan was referred to the Board of Censors and the secretary instructed to write the doctor that it would be necessary for him to give up examining for the New York Life Insurance Company before becoming a member of the society.

Dr. Sheely gave a very interesting report of the meeting of the Mississippi State Medical Association, stating that the papers were above the average and very interesting and instructive. B. Z. Welch.

Book Reviews.

PRACTICAL POINTS IN NURSING FOR NURSES IN PRIVATE PRACTICE with an appendix containing rules for feeding the sick, recipe for invalid foods and beverages, weights and measures, dose list, and a full glossary of medical terms. By Emily A. M. Stoney late Superintendent of Training School for Nurses, Carney Hospital. Boston, Mass. Fourth Edition, thoroughly revised, containing 97 text illustrations and 8 colored and half-tone plates. W. B. Saunders Company, Philadelphia and London. 1910. Price $1.75.

Miss Stoney's little volume, which is one of the standard text books in the training school for nurses, is so well known that words of praise are entirely superfluous. We simply desire to call the attention of physicians to the fact that it contains information of much value to them, information which if possessed by the average practitioner would often smooth down little obstacles in practice. We would venture to suggest that the illustration on page 82, showing the method of giving a hypodermatic injection is incorrect teaching, as it is less painful to give an injection in the course of the nerve fibres than against them. The printer has placed Fig. 45 on page 153 sideways, which entirely destroys its value as an illustration. The subject matter is without reproach and the book is the best of its kind on the market. Myers.

THE PRINCIPLES AND PRACTICE OF MODERN OTOLOGY. Second Edition Revised. By John F. Barnhill M.D., Professor of Otology, Laryngology, and Rhinology, Indiana University School of Medicine; and Ernest de W. Wales B.S., M.D., Clinical Professor of Otology, Larynology and Rhinology, Indiana University School of Medicine. Octavo of 598 pages, with 305 original illustrations, many in colors. W. B. Saunders Company, Philadelphia and London; 1911. Cloth, $5.50; Half Morocco, $7.00 net.

In the second edition no very extensive changes are made and the text follows closely the first edition of this work. The chapter on the examination of the function of the ear has been rewritten, and new matter added includes a description of the Heath mastoid operation and several photographs relating to labyrinthine suppuration. The arrangement of the text is very good and the book is recommended to any physician needing an up-to-date text-book on this subject. The presswork is excellent and the illustrations, which are very profuse and well chosen, are above the average. BELL.

1000 SURGICAL SUGGESTIONS. By Walter M. Brickner B.S., M.D., Adjunct Surgeon Mount Sinai Hospital, Editor in Chief American Journal of Surgery, with the collaboration of James P. Warbasse M.D., Harold Hays M.D., Eli Moschcowitz M.D. and Harold Neuhof M.D. 225 pages. Cloth Bound Semi-de-Luxe $1.00. Surgery Publishing Company, 92 William Street, New York.

This is one of the biggest little books ever presented to the profession. In its 225 pages are found a collection of 1,000 epigrammatic, succinct, virile and instructive hints based upon actual experience and every one a lesson in itself.

The Suggestions are so arranged and indexed that all subjects covered can be immediately referred to and the particular hint upon any particular subject immediately found. It bristles with pointed and useful suggestions which in many cases might just turn the scale from failure to success. Its mechanical presentation is a feature worthy of mention. It is square, cloth bound, stamped in gold, printed upon India tint paper with Cheltenham type, with special marginal side headings in red. A dollar could not be better invested than in the purchase of this book. MYERS.

PLASTER OF PARIS AND HOW TO USE IT. By Martin W. Ware M.D., N. Y., Adjunct Attending Surgeon, Mount Sinai Hospital; Surgeon to the Good Samaritan Dispensary; Instructor of Surgery in the New York Post Graduate School. Second Edition, revised and elarged. Price $1.25. Surgery Publishing Company, New York.

Such information as History, Materials, Manufacture of

Bandages, Storage, Bandages of Commerce, Calot Plaster Bandages, The Immediate Preparation of Bandages, Application and Precaution, Removal of Bandages, etc., are all given under the contents of The Plaster of Paris Bandages. Then follow such chapters as Application of the Plaster of Paris Bandage to Individual Fracture, Fractures of the Upper Extremity, Fractures of the Lower Extremity, Moulded Plaster of Paris Splints, Plaster of Paris in Orthopedic Surgery, etc., and all presented in such a comprehensive manner as to make this book of particular service to every doctor. The mechanical features of the book are decidedly striking.

MYERS.

GOLDEN RULES OF DIAGNOSIS AND TREATMENT OF DISEASE. By H. S. Cables B.S., M.D., Professor of Medicine in College of Physicians and Surgeons.

GOLDEN RULES OF PEDIATRICS. By John Tohorsky A.B., M.D., Clinical Professor of Pediatrics Medical Department Washington University, St. Louis, Mo., etc., with an introduction by E. W. Saunders M.D., Professor of Diseases of Children, Medical Department Washington University. C. V. Mosby Co., St. Louis, Mo. Price $2.50.

These little works, like all the rest of the Golden Rules series consist of a collection of aphorisms and reminders, which in the hum of practice may be consulted with benefit by physicians, particularly in cases where every remedy seems exhausted, it is agreeable to turn to a work like one of these and find in succinct phrase just the reminder needed. These works are in no way intended to take the place of the larger textbooks, but merely act as signposts, blazing the trail, which may be followed further in more pretentious works. They admirably fill the niche intended, which is more than can be said for some much larger works.

MYERS.

NEW AND NON-OFFICIAL REMEDIES. The A. M. A. has put out another edition, revised to date, and furnished its members with copies gotten up in style similar to the *Journal*. It contains the material along the lines indicated by the title that has been run from time to time in the *Journal*. It may be had in cloth binding and more convenient size for fifty cents.

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MISSISSIPPI MEDICAL MONTHLY

VOL. XVI. JULY 1911. NO. 3

*TWELVE MONTHS WORK IN OBSTETRICS, WITH COMMENTS.

B. L. CULLEY M.D.,

JACKSON.

In reporting my work in obstetrics for the last twelve months I will mention some forty or fifty cases of which I have kept a partial record. Before giving any special statement of these cases I wish to say that I do not believe that the subject of obstetrics is given the consideration by teachers and practitioners the importance of it deserves. The old idea of half a century and more ago seems not to have gotten away from a great many of the physicians of today; that is, that the only duty we owe is nothing more than that of a midwife. To my mind there is not a subject of more, if of as much, importance in any department of medicine, and certainly none that has more to do with the health and happiness of woman. The obligation resting upon the physician should be of vast concern to every one who proposes to do this line of practice. When we consider the many conditions arising in consequence of the lack of proper attention before, during and after confinement, not only to the mother, but also to the offspring, we should, as far as possible, give our patrons to fully understand the importance of having the prospective mother under close observation from the time gestation begins, so that we may direct her in all matters pertaining to her health; also her social and moral environments should be considered of much importance, so that she may go through the gestation, confinement and puerperium without accident. Neglect of our duty to the woman at these times is the chief reason of the gynecologist who grows fat on the results consequent to the mistakes or negligence of the obstetrician.

I do not claim that I am without fault in this matter. My past experience in obstetrics has convinced me that he who proposes to do obstetric work must be well equipped, not only in obstetrics and in general medicine, but he needs to

*Read before the Mississippi State Medical Association, 1911.

be well abreast in the principles of practical surgery if he would meet with promptness the emergencies that arise in the obstetric field. Of some forty cases of which I have a record there is only one negro. My practice being largely in the generally well-to-do class of people will account somewhat, possibly, for the comparatively good results. In this record are included abortions and miscarriages. The ages of the mothers are as follows: four, sixteen to twenty; twelve, twenty-one to twenty-five; twelve, twenty-five to thirty; six, thirty years and over; one, thirty-six years.

Of the total mothers, fifteen had one child; twelve, two; five, three; three, four; two, five; two, six; and one eight children. The vertex presented in all except one, a breech. At beginning of labor the position was in nineteen L. O. A., in five R. O. A., and one O. P. Of the others I made no record as to position and presentation. There were three abortions, two in second month, one in third month, and one miscarriage in the seventh month. The cause of abortions was typhoid in one and pneumonia in one, followed by empyena, operation and death of mother after one week. There was no death of a mother at full term and no case of puerperal fever, and only one child (colored) lost. This last, and the only colored woman within the last twelve months, is worthy of mention. This woman gave the history of having gone into labor at what was supposed to be her full term, pains continuing for a day or two, when they stopped; she then went one and a half months before labor set in again, and had been in actual labor for forty-eight hours when I saw her in the care of a midwife who gave the above history. On examination I found the head very firmly fixed in the pelvis, apparently in normal condition. After proper preparation I applied forceps, but could make no impression.

I then sent for assistance, which responded in the person of my friend, Dr. Wall, who made several attempts at delivery, but with the same result as myself. We decided to do a craniotomy. The sutures and fontanels were closed, requiring at least five or ten minutes to perforate through the fontanele. The cranial bones could not be removed except by frequent bites of the osteotribe.

The mother had no marked disturbance during the puerperium.

One case of abortion induced by me was caused by a complete retroversion of the uterus and pernicious vomiting for the past three months. The mother died as the uterus was emptied, from inanition.

This case came into my hands four days before the unfortunate result. One case of post-partum hemorrhage, two hours after labor. One case of post-partum eclampsia and recovery. Albumen was present in four cases just before labor set in. One case on hand now, seventh-month gestation. We induced labor in this case four days ago. The child lived only a few hours and the mother's life has been in the balance ever since. For forty-eight hours there was almost total suppression of urine. A more nervous creature than this woman I have never seen. You will note in the large majority in this report cases of one and two-child sterility. This has been largely the case in my experience of some thirty years' practice. This is one of the signboards of race suicide, making it evident that something is being done to prevent conception or to destroy the fruit of the womb. Forceps were used three times, two of these in consultation with Dr. Shands, he using the forceps in his cases.

My own case I have reported above, with results. One child was lost of Dr. Shands' two cases. The instruments were absolutely necessary in these three cases. I used chloroform in the majority of cases, and believe in the use of forceps, but not to save time for the attendant.

Before closing this paper I wish to report two cases of hematamesis of the new-born, one a year ago, in which the blood was vomited and passed through the bowels until the infant was exsanguinated. I gave adrenalin hypodermatically and saline enemas, with complete recovery after a protracted anemia.

The second case is now on hand, which began vomiting blood on the fifth day after birth. The hemorrhage is not sufficient yet to produce anemia. I am giving one-drop doses of adrenalin by mouth in salt water every two hours. Both of these children at birth were above the average weight and apparently normal in every respect.

I have had two cases of ruptured funis, one as the child was delivered, it being completely exsanguinated and could not be resuscitated. The cord in the other two was torn from the navel at the expulsion of the child through the vagina. The hemorrhage could not be stopped except by grasping the navel with the clamp. A ligature was finally applied, which prevented any further hemorrhage. I hope I have not burdened you, gentlemen, with the length of this paper, and in its writing I trust it will elicit full discussion.

*ACUTE HYDRAMNIOS, COMPLICATED WITH ASCITES. REPORT OF THE CASE.

F. J. UNDERWOOD M.D.,

NETTLETON.

One year age, after I had stood before this Association and told you about my troubles with abortion cases, and recounted one case of inevitable abortion especially, and a number of you were kind enough to discuss my paper freely, I went home "full to busting" with obstetrical information, thinking surely I was now complete master of any obstetrical problem that can possibly pop up.

On a certain hot, sultry night of last August this idea left me very suddenly, and I have been very penitent every day since with foreboding of evil.

The case I wish to report, a case of acute hydramnios complicated with ascites, may not be interesting to you, especially the old veterans, but I assure you that it gave me some food for thought.

On the night of August 22nd. 1910 I was called to Maria Hogan (negress). She was five and one-half months pregnant, primipara, age twenty. From the history that I was able to get, her pregnancy had been uneventful up to about fifteen days previous to this time, when the abdominal distension was very conspicuous. When I was called she was large enough for full term. She was greatly depressed, had an irregular, quick pulse, dyspnoea and temperature of 102° F. Physical examination revealed ascites. She was not very fleshy and fluctuation could be plainly detected on both sides and above the uterus.

I decided upon a course of medication, which I proceeded to prescribe, the treatment to last twenty-four hours. Seven hours after I saw her I was called by 'phone in great haste, the party at the 'phone telling me that she was sinking. Upon my arrival her sister said that she had been threatened with heart failure for an hour or two. I found serious cardiac disturbance and her abdomen had enlarged to fierce proportions. I asked for consultation, and that quick, and while waiting for his arrival I decided that I would try paracentesis for temporary relief; but this was a failure. After the consulting physician arrived we decided to at once try the induction of abortion. I informed the husband of the gravity

*Read before the Mississippi State Medical Association, 1911.

of the situation and he and his mother-in-law asked us to do what we thought best.

After she was anesthetized, the vulva, vagina and cervix were cleansed and disinfected. I gradually dilated the cervix to the size of a silver half-dollar, ruptured the membrane and permitted the discharge of one gallon of water slowly. This gave great relief; her heart beat stronger and lost its wavering irregularity; her dyspnea disappeared and all symptoms pointed to improvement. She was allowed to come out from under the anesthetic, for she had begun having pains of a bearing-down nature. In four hours the uterus emptied itself of all contents, with no untoward symptoms following. The child was dead. Mother's recovery complete.

I examined the foetus, umbilical veins and placenta, and found nothing to clear up the cause of trouble. Family history very good. Don't think she had syphilis. There were no lesions of the heart, blood vessels, liver or kidneys. There was very little oedema of the extremities. No diabetes, no albuminuria. When I called the next day her mother told me that her husband had "kicked her in the bowels" about two weeks prior to the trouble, and I then thought that the kick had caused an inflammation of the amnion itself, which caused all my trouble.

I report this case to you for what it is worth, and will welcome criticism.

---

*LIMITATIONS OF A LABORATORY,

HAROLD B. WOOD M.D.,

JACKSON.

In the detection of the obscure causes of disease the laboratory findings are not necessarily pathognomonic; but, like any physical sign, they must be correctly interpreted that the significance of the results may be justly estimated. Examinations are made to detect a definite sign or to reveal a certain condition rather than to determine a whole course of events. They are differential rather than purely indicative. A laboratory is a place of consultation where the cause is sought after the effect has been noted; it is the final rather than the primary step in diagnosis. It is the means for acquiring additional data that the existing conditions may be the better understood. Laboratory diagnoses are not intended

*Read before the Mississippi State Medical Association, 1911.

to supersede but to assist in the analysis of clinical observation. The findings are to be weighed with the clinical evidence and not to be accepted to the total exclusion of any consideration of physical signs or symptoms.

When a patient has a disease which simulates another, the laboratory and clinical findings may be at variance. In such an instance the true condition is apt to be detected by the instruments of precision. If, however, a person be afflicted with two conditions, only one of which may be discoverable by the laboratory, the other condition may not be suspected nor sought by the physician if he is inclined to consider only the laboratory evidence. Under such circumstances the lack of improvement in the patient would unjustly stamp a conviction of limitation on the use of the laboratory.

There is a possibility of a person being a carrier of one condition but a sufferer from an entirely different malady. The limit of power of the laboratory prevents its detecting the cause of the latter incumbency, and when it discovers the harmless state the physician believes it to err, as no clinical evidence warrants the findings. It is the infectious carrier rather than the infected case which becomes a menace to society, and is frequently discoverable only by laboratory methods. A person may be a carrier of germs which, though pathogenic to others, are so attenuated in this host that they are harmless. Pathogenicity in most organisms may not be discoverable by stains, hence a bold report of finding the organisms has its limits of usefulness. It is, however, of value to make known their presence, for if permitted to escape they may become actively virulent to another individual. The value of detecting their existence in the former person is largely to save the latter.

In the light of such usefulness any laboratory becomes a tool for the protection of the public health, rather than merely a means of assisting the individual. Pathogenic germs should be discovered not alone for purposes of diagnosis, but to learn if the individual is a danger to others. When the virulent organisms are found escaping from any individual, if successful means are not adopted to disinfect, then the field of usefulness of the laboratory receives a check in the household.

A positive laboratory finding means that the conditions sought have been demonstrated; that the bacilli, for instance, were found; without necessarily making a diagnosis of illness or suffering on the part of the patient. If the clinical evidence of disease corresponds to what might be caused by the organism discovered, the nthe patient should receive the treatment appropriate to that condition. If no signs or symptoms exist

to account for the specific germ, then the patient is considered a carrier and should be watched or treated that he may not give way to the germ, and he should be safeguarded so as not to become a danger to others.

A negative diagnosis means that the organism sought has not been detected, owing to the absence of the disease, to defective technique in collecting and examining the specimen, to incorrect time of collection, to action of drugs taken, or to the death or disintegration or scarcity of the organisms in the particular specimen. Negative does not mean "non-existing" but "not found." A negative report means that under the conditions of examination the object sought was not demonstrated; it emphatically does not mean that the suspected disease does not exist. A negative laboratory finding does not necessarily nullify a clinical diagnosis. If the signs of the suspected disease are strong, even in the face of a negative laboratory report, the patient should receive the appropriate treatment—as in typhoid fever, diphtheria or tuberculosis—until repeated clinical or laboratory examinations clear all doubt and the patient is proven free from the infection. A bacterial examination on which an incorrect interpretation has been placed is misleading and worse than useless.

The value of demonstrating the actual presence of tubercle bacilli in the sputum of a patient suspected of having tuberculosis is apparent. In probably no other affection does recovery, as well as the safety of the patient's associates, depend in so great a degree upon a correct and early diagnosis. Much more than for a diagnosis alone, examinations are made to determine if the sputum is infectious with tubercle bacilli, that it may be handled accordingly. But there is a limitation to the laboratory in this work. If the patient is discharging only a few hundred bacilli a day, there may be none detected in the examination. Knowing that every cough is not due to tuberculosis, the physician should not accept a single negative laboratory finding as a declaration of the absence of a tuberculous process. The presence of tubercle bacilli in the sputum means the existence of an active tuberculous process in the body. Tuberculosis which dose not cause sloughing off of the tissue into a bronchus would hardly be expected to reveal the tubercle bacilli under the microscope; hence a person can succumb to the disease without giving the microscopic diagnosis. In the incipiency, as in any other stage, there may be few or there may be many bacilli discharged. A negative laboratory finding in a suspect may suggest the collection of another specimen under different conditions or a repetition of the physical examination. A negative result, under some conditions, may

mean nothing. If the specimen is pure saliva it is not apt to show the bacilli even though the patient be quite markedly infected. A thin, watery specimen ejected without difficulty and without coughing, is probably all saliva, and useless for diagnostic purposes. The early morning expectoration is the most desirable and satisfactory because during the previous hours of quiet the ciliae of the bronchial mucosa have had the best opportunity to sweep upward the bacilli, which can be then easily collected. This morning specimen will contain few extrinsic bacteria, many leucocytes and whitish mucin. In such a specimen the tubercle bacilli may be found. But in the watery secretion containing large numbers of various bacteria, food particles and colorless mucus, a search for pathogenic organisms is usually futile They are not apt to be found in the result of a hemorrhage. The finding of a single tubercle bacillus after a prolonged search does not qualify as a positive result, for this one germ may be adventitious, though this is not probable.

Tubercle bacilli are recognized by their tinctorial characteristics, their morphology receiving only scientific interest as yet. Morphologically, tubercle bacilli are long, medium or short, broad or narrow, solid, broken, branched, chained, beaded or clubbed, but usually exhibit little variation in a given specimen. Craig thought the beaded forms were most often found in the rapidly advancing cases; but Rosenberger, in a study of the clinical histories of one hundred and forty-six cases, found that in the unfavorable cases darkly stained, solid bacilli were found, with fractured forms common. In the favorable cases the bacilli were thin, staining faintly.

The number of tubercle bacilli soon has no constant relation to the severity of the disease, but usually they are more numerous in the unfavorable cases. This factor of number becomes of concern mainly in preventive medicine. The greater the number of pathogenic organisms being given off by the patient, the greater should be the care taken to have disinfection done around the patient, for the greater would be the danger to others. If few bacilli are found, the precautions of safeguarding the people need not be so exacting, but the chief channels of dissemination—cough and spit and drinking—should always be kept under rigid sterilizing control.

The examination of milk for tubercle bacilli is not very reliable unless inoculation into guinea pigs is performed.

The bacteriological diagnosis of diphtheria is based more on the morphologic than cultural characteristics. It is of distinct advantage to make an immediate smear preparation directly from the swab, rather than to wait first for the blood

serum culture. If in the smear a number of minute, polar-staining, club-shaped bacilli, arranging in Vs, parallel or fan-shaped masses, are seen, a positive diagnosis is assured. An examination of the yet-invisible growth after six hours' incubation may confirm the diagnosis. If incubated for twelve hours or longer, the diphtheria bacilli may be obscured by an excessive growth of other organisms and not found. McFarland directs to wait for ivory-colored colonies, looking for the polar staining. Holmes trusts more to the position assumed by the bacilli than to the varying morphologic characters.

The laboratory finding may be negative in an undoubted case of diphtheria because of the

1st. Swabbing not being done with sufficient firmness nor on the infected area.

2nd. Disappearance of the germs from the surface from the effect of antiseptics, antitoxin, or swallowing.

3rd. Death of the organisms before reaching the laboratory.

4th. Scarcity of organisms.

A negative finding in diphtheria has greater significance than in any other disease, for if the germs existed, there is a greater probability of their detection. The positive finding of diphtheria bacilli does not necessarily indicate the giving of antitoxin, the advisability of such theory being judged from other evidences of illness. If there is a possibility of the person who exhibits the specific organisms developing symptoms of diphtheria, or if the germs cannot be reached by local antiseptics, there should be no hesitation in giving antitoxin. The mere finding of diphtheria bacilli creates a demand for the use of effective local antiseptics and the rigid enforcement of other measures which will prevent transmission of the disease. It is a warning that the person examined is a public menace and must be treated as such. Controlling measures should be persisted in until a laboratory pronounces two successive examinations as not showing the diphtheretic bacilli.

The limitations of laboratory exactitude in diagnosing malaria are largely dependent upon the method of making a blood smear, the time of collecting the blood, and upon the previous administration of quinine. The drop of blood should be scraped out as an almost invisible yellowish film on a glass cleansed of all grease, and should not be a drop of moist blood pressed flat between two slides. The time of taking the blood had best be from four hours to one hour previous to the expected chill. The giving of quinine has a tendency to cause a disappearance of the plasmodia from the peripheral blood, and hence should not be given within a week or two before

making the blood smear. The distinctive parasite appears in the blood in from five to twenty-two days after the bite of the insect, but at times it may be impossible to determine from the blood smear exactly the type of infection.

The microscopic examination of excremental matter yields a field of great usefulness in sections where intestinal parasites abound. The fact that a microscope may not reveal the ova of a patient infected for years by hookworm disease is more than counterbalanced by the unquestioned superiority of microscopic over clinical examinations in detecting lightly infected cases, or in those in whom the typical signs may be masked by another condition. The formerly accepted method of diagnosing tapeworm disease by finding the proglottides has been wisely superseded by the microscopic search for the spherical, striated ova. In one county of this state there has been what may be termed an epidemic of hog measles, many hogs slaughtered showing the presence of the cysticerci cellulosae. A widespread microscopic examination, by detecting the tapeworm infection in man, would locate the original sources of infection and assist in checking a further loss in the hog industry.

In the differentiation of typhoid fever the Widal agglutination reaction of the blood may be useful, but the diazo urine test may be frequently obtained one or two days earlier. A diazo reaction in the presence of negative Widals is strong presumptive evidence of tuberculosis. A typical Widal reaction is rarely obtained during the first week of fever. There is a possibility of the blood having retained agglutinality from a previous typhoidal attack. If the blood is heated in the drying, the power of agglutination is lost.

In the investigation of the cause of endemic typhoid recourse to laboratory examination may be of value, but in a sudden outbreak little may be learned. In the outbreak the milk, water or other food which has been the transmitting agent may have become free of the bacilli before the first cases of the disease appear. In a single temporary infection it may be a hopeless task to discover the infective organisms.

Too great delay should not be permitted before beginning to search for the transmitting agents in an outbreak of any transmissible disease. In Mississippi it would be well to adopt some arbitrary number, as ten for a city and three for a village, to indicate the number of cases occurring in a specified limited time to constitute an epidemic requiring investigation.

In considering epidemics, as of typhoid fever, the contact cases coming as secondary cases to the original ones should not be grouped nor classed with those to be investigated.

These contact cases are those in the infected household arising from soiled hands, soiled clothing, eating utensils, flies, ants, bedbugs or mice, etc. In investigating such cases bacteriological examinations will avail little.

The identification of the typhoid bacillus in water is a long and tedious process. Since colon bacilli abound where typhoid bacilli are found, it is usually considered sufficiently strong evidence to prove the existence of the colon bacilli. The indicator of pollution being found, a personal inspection of the premises determines the manner by which these organisms gained access to the water. A personal inspection can sometimes determine much more than a laboratory, but the latter may be used to supplement it. The inspection determines primarily if the contaminating organisms were human in origin or from the lower animals; and the means of entrance, whether by surface rain washings, trackings by animals, winds, subsoil fissures, broken sewerage or ground seepage. When sewage is seen flowing into a water supply, no laboratory examination is necessary to pronounce the water unfit. In many cases a personal inspection would reveal much more information than a chemical or bacteriological examination To resort immediately to a water analysis is analagous to an effort to make a diagnosis of any disease by only analyzing the urine as the first step, ignoring all clinical study of the patient. Both analyses have their value but should not receive the initial place.

To make haphazard chemical or bacteriological examinations without having previously well-grounded suspicion needlessly consumes much valuable time. If the evidence of contamination of a supply is very strong, it may be best to condemn even in the face of negative laboratory findings.

A microscopic or chemical examination is of undoubted value in differentiating diseases which have a tendency to simulate one another, in diagnosing typical cases in their early development and in detecting obscure causes of disease. A laboratory has its definite place and its availability is being accepted more and more by physicians. Too much should not be expected of it, and too much should not be required from the examination of specimens, especially when they are in the best of condition. Many specimens, when not properly collected, will not admit of a satisfactory examination. To assist the laboratory man in arriving at a definite conclusion he should be instructed as to what particular object is to be sought, from what part of the body the specimen is obtained, and should be given other useful data. Thus the clinician and the laboratory man may by their labor co-operate to the advantage of the community.

*OBSERVATIONS MADE IN SIX CASES OF MECHANICAL ILEUS.

H. R. SHANDS M.D.,

JACKSON.

Intestinal obstruction is such a broad subject that I shall not attempt to go into the classification, etiology and general symptomatology, but rather restrict myself to the interesting facts which I observed and learned while treating the following six cases. I will report the cases very briefly and dwell especially on the unusual points to be brought out in each case.

Case 1.—Mechanical ileus due to volvulus of ileum around a peritoneal band following a suppurative appendicitis. This patient, male, aged twenty-four, when first seen had been suffering with severe intestinal colic for sixty hours; no faeces or flatus had passed for forty-eight hours. He had been operated upon twelve months before this for an appendiceal abscess. He was extremely ill at the time of this operation, but had regained good health and retained it for twelve months before the obstruction occurred. The case was seen in consultation with Dr. Culley of Jackson. After a futile rectal irrigation we agreed on the diagnosis of mechanical obstruction and advised immediate operation. No tumor or other sign was present to guide us, so we judged that the obstruction would probably be near the ileo-cecal valve, and made the incision through the right rectus. Upon entering the peritoneal cavity we found distended coils of intestine, which were followed down to the obstruction. This had occurred in the ileum, ten inches from its distal end. Here we found a fibrous cord two inches long and about as thick as a shoestring. A loop of ileum was twisted around this, producing a complete mechanical obstruction. The bowel was not gangrenous, so we excised this band and one or two others that we found, and closed the abdomen. The patient made an uneventful recovery and was out of the hospital in ten days. He has since remained well.

In intestinal obstruction following a preceding peritoneal infection of any kind, suspect bands of adhesions as the cause of the obstruction.

Nature is wonderfully efficient in disposing of the great plastic exudate so frequently thrown out around intra-peritoneal pus. When the exudate binding the intestines together becomes too firmly organized to be absorbed, the normal peri-

*Read before the Mississippi State Medical Association, 1911

stalsis of the intestines frequently loosens the broad agglutinated surface and draws it out into a strong connecting cord. The wonder is that obstruction does not occur more frequently after intra-peritoneal pus.

I recently diagnosed a case of this kind which was taken to the Gulf and Ship Island Hospital at Hattiesburg for treatment, in which the obstruction followed two years after a non-operated gunshot wound of the abdomen.

Case II. Typical Intussusception.—Male child, aged seven months, seen with Dr. Hall of Clinton. This baby had been sick for thirty-six hours when seen by me, having had no movement from the bowels in this time except a little bloody mucus. He was now writhing with colic, and a banana-shaped tumor could be easily felt in the left hypogastric and iliac region. Dr. Hall had already diagnosed intussusception, and had wisely refrained from giving a purgative. In this diagnosis I concurred. We fortunately could catch a train back to Jackson, and operated at 11:00 o'clock that night. At the time of the operation the little patient was desperately ill. An incision was made through the left rectus and the tumor delivered. The ileo-cecal valve and appendix had descended to the lower part of the sigmoid. The bowel was not gangrenous, so the operation was quickly finished. Recovery was prompt and entirely uneventful.

Case III.—Male child, aged twelve months, first seen by me at 12:00 o'clock, noon, May 18th. 1910. The patient had been taken with a severe colic three hours before this. He was pallid and writhing with pain. On account of the extreme suffering and prostration I suspected intussusception at once, and so informed the mother, advising that we give an enema and watch him a few hours before instituting treatment. No purgative was given. The enema brought away only a little bloody mucus, no gas or flatus. After five hours, with the assistance of chloroform anaesthesia, we could feel a sausage-shaped tumor in the epigastrium. The patient was immediately removed to the Baptist Hospital and operated upon at 6:00 p. m., nine hours after the inception of the obstruction. The abdomen was opened through the right rectus, the tumor delivered and the intussusception rather easily reduced. Bowel not gangrenous. This patient also made a prompt recovery.

Different advice is given as to the necessity of any procedure looking towards a prevention of a recurrence of the intussusception. The methods generally used to accomplish this are either to fold the mesentery of the bowel upon itself, thereby shortening it, or to tack the caecum to the parietal peritoneum at its normal anatomical site. If the mesentary

is folded upon itself, there is some danger of interfering with the blood supply of the affected bowel, possibly already none too good. Considerable trouble will often be experienced in tacking the caecum in its normal position to the parietal peritoneum. In operating for intussusception, the incision should be made at that place which will allow the tumor to be delivered must easily. Sutures cannot readily be introduced into the parietal peritoneum around McBurney's point, through a moderately small incision some distance removed from this point. On account of these difficulties there is a great temptation to omit anything not absolutely essential, which will prolong the operation upon these patients, as a rule desperately sick and most often infants. Still, if nothing is done to prevent a recurrence of the intussusception, the operator cannot maintain a comfortable degree of equanimity during the post-operative period, and there is occasionally a recurrence, which generally means a dead patient. These little patients don't stand well a second operation.

In the second case above cited I adopted a precedure to prevent a recurrence of intussusception, which, so far as I can ascertain, is original, and is, I believe, good. I noticed in both of these cases that the apex of the intussusceptum was not the ileo-cecal valve, but a point on the base of the caecum just beside the appendix. This point was the last to be reduced and a dimple remained in the base of the caecum marking this point after complete reduction. This is the type of intussusception described by Lorenz as invaginatio-caeco-colica. When the intussusception was being reduced the last part of the bowel to appear was a long, congested appendix. I decided to utilize this appendix in immobilizing the caecum so as to prevent a recurrence. I did this very much after the method described by Dr. Stafford of the Marine Hospital Service for doing an appendicostomy. Briefly, the method used was this: The fingers of the left hand were introduced through the primary incision into the right iliac fossa and pressed against the parietal peritoneum at McBurney's point on the inside. A small stab-wound was made from the outside down to the finger at this point on the inside. Through this stab-wound an artery forceps was introduced and the tip of the appendix caught. The entire appendix was now withdrawn through the stab-wound, pulling the caecum snugly against the parietal peritoneum at its normal anatomical position. The appendix near its base was sutured to the edge of the skin of the stab-wound. As an additional safeguard a string was tied around the appendix near its base on the outside of the abdomen and the long ends of the string securely fastened with adhesive

plaster to the skin of the abdomen lower down. If necessary, a portion of the mesentery of the appendix can be ligated and cut near the appendix, thereby enabling the appendix to be more readily drawn through the stab-wound. The original incision was now completely sutured.

This method of preventing a recurrence of the intussusception presents to my mind the following advantages:

First—It absolutely prevents a recurrence. Every other baby in your practice may have an ileo-cecal intussusception, but a caecum thus treated can never again even begin a journey through the colon towards the anus.

Second—It can be done very quickly, certainly within five minutes.

Third—It can be done through the primary incision; it makes no difference in what part of the abdominal wall this has been made. Even if the incision has been made in the left rectus, the hand can be introduced into the abdomen so as to enable the finger to reach McBurney's point on the inside. Incisions on the left side are necessarily made longer because the ileo-cecal valve has descended further along the colon and sigmoid, and the tumor is necessarily larger.

Fourth—The appendix is removed. The appendix may serve some useful function; however, it can never be of greater service than in thus absolutely preventing a recurrence of this intussusception.

Fifth—If the patient is weak and needs stimulation or nourishment you can easily have an open channel into the caecum through which to introduce a small catheter and pour salt solution or liquid nourishment.

The appendix is drawn through the abdominal wall at least two inches from the laparotomy wound, so there need be no fear of an infection of the primary incision from the mucosa of the appendix. In this case both wounds were firmly healed within two weeks.

In passing I will state that I believe the type of intussusception described by Lorenz as invaginatio-caeco-colica to be more common than is generally conceded. However, it makes no difference what type of a caecal intussusception you may have, this procedure will certainly prevent its recurrence.

Case IV. Internal hernia and volvulus through omental rent.—Colored female, aged forty, seen in July 1910, in consultation with Dr. Peter Fairley of Jackson. Dr. Fairley had already diagnosed intestinal obstruction when I was called. When we saw the patient together she had been unable to get a bowel movement for eight hours. She was greatly distended and had vomited frequently, though her pulse and general

condition were fairly good. There was nothing in the history, symptoms or signs to indicate the anatomical position of the obstruction, though we judged that it was rather low down in the intestinal tract. When the obstruction occurs in the duodenum or jejunum the serious symptoms come on, as a rule, much more rapidly than they had in this case. Having no guide, the abdomen was opened in the median line, below the navel. The obstruction was readily located. The free edge of the omentum had become adherent in the pelvis to the parietal peritoneum. Several feet of ileum had herniated through a slit in this adherent omentum and become twisted after passing through the slit. This part of the omentum was excised and the obstruction relieved. The patient made a prompt recovery.

This case illustrated to me that intestinal obstruction can easily be successfully and radically treated, even though no hospital is available. This patient lived in an ordinary negro house three miles from Jackson. We drove there prepared for the operation, performed it, and were back in Jackson two hours and fifteen minutes after leaving.

Case V.—Obstruction caused by a sponge left in the abdomen at former operation. Eight months before the development of this obstruction this patient had been operated upon in a neighboring city for pus tubes by one of the most careful and skillful surgeons in the South. Following this operation she had suffered a great deal of pain in her abdomen and had rather a stormy convalescence. The wound, however, healed well and she left the hospital in two weeks. For the next eight months she was able to be up, but never felt well and often had pain and soreness in her lower abdomen. I was summoned to her at 6:00 p. m., July 30th. 1909, and found her suffering greatly with abdominal cramps. She had been suffering this way for fourteen hours and had obtained no relief or bowel movement, though she had taken several large doses of salts. The temperature was normal and general condition very good. After examining her I informed her that I suspected intestinal obstruction from post-operative adhesions. I sent a nurse to her to try through the night to obtain a bowel movement with the rectal tube. By next morning she was vomiting and the nurse reported that she had been unable to get any faecal matter with her enemata. We operated upon her at 9:00 a. m. Upon opening the abdomen I found innumerable firm adhesions and with great difficulty worked my way down through the intestines. Finally a large mass was located in the cul-de-sac. This mass was so firmly imbedded in organized adhesions that it at first felt as if it might be a

malignant tumor. When I delivered it into the wound I discovered it to be the sigmoid, with a large black mass filling its lumen and extruding into the abdominal cavity through an opening an inch in diameter in the wall of the sigmoid. I pushed the mass down the sigmoid and rectum and had the nurse pass her finger into the anus and withdraw it. I now closed the opening in the sigmoid and closed the abdomen, leaving free drainage. The black mass proved to be a gauze abdominal sponge about twelve inches square.

Nature, in its effort to get rid of this foreign object, had caused it to ulcerate its way into the sigmoid. The sponge was so large that it totally occluded the sigmoid and could go no further, thus causing the obstruction.

This patient developed a faecal fistula during convalescence, but made a good recovery and is now in excellent health.

The leaving of a sponge in the abdomen at operation is to the lay mind an absolutely inexcusable accident, and has been the cause of many damage suits. This accident, however, may occur very much more easily than one unaccustomed to intra-abdominal work would think. In fact, the only way it can be prevented is by following religiously one of the several good techniques devised for its prevention. Any patient who has a sponge put into her abdomen without having something hitched to the sponge and left on the outside is in serious danger. It makes no difference how careful the operator is, eventually he will overlook a sponge unless he has something on the outside to mark it. During my interneship in the Louisiana Charity Hospital I saw one or two post mortems in which death was caused by this oversight. The operator who finds a foreign body in the abdomen left at a former operation should be very discreet. It can do the patient no possible good to tell the cause of his illness, and may get some brother physician into very serious trouble. Then, too, there is no good accomplished in shattering the patient's faith in one whom he has formerly trusted with his life.

None of you here to-night who do abdominal work can be certain that this accident will not some day happen to you. I confess that I have once already experienced it. Fortunately my patient recovered and I removed the sponge without her ever knowing how it got there.

I heard Dr. Will Mayo say that he had much more respect for the surgeon who accidentally left the sponge than for the one who found it and told.

In this case we told the patient that we found intestinal obstruction, and this satisfied her. She did find out six months afterwards from her sister, who was present at the operation,

the cause of the obstruction. However, both she and her sister were devoted to the surgeon who did the operation and were not in the least disposed to cause him trouble.

Case VI.—Intestinal obstruction caused by adhesion of omentum to ulcerating tuberculous lymph node in lower lumbar region. This patient first came to Dr. Hunter of Jackson with left inguinal tuberculous glands. Three months after this he turned up with an acutely inflamed appendix, which we removed. Immediately following this he had an acute hemorrhagic specific cystitis and prostatitis superinduced by post-operative catheterization. Two months after this he was treated by Dr. Catchings of Hazlehurst for a pleuro-pneumonia which left a pleural effusion. He was put to bed in the open air with forced feeding and a general anti-tubercular treatment instituted. In two months more he developed positive intestinal obstruction. He was a veritable Job. At the time of the operation the obstruction had been complete for thirty-six hours and his suffering was very great, with general condition desperate. He was operated upon at the Baptist Hospital, April 2nd. 1910, at 9:00 p. m. We made the incision through the right rectus, thinking the obstruction was probably caused by some adhesion around the base of the appendix. We, however, found the inflammatory mass causing the obstruction just over the brim of the pelvis at the promontory of the sacrum. The omentum was densely bound down to the posterior abdominal wall, having a piece of ileum caught under it and twisted about it, thus causing a complete occulsion of the lumen of the intestine. All of this inflammatory mass was excised and the intestine thereby liberated. The abdomen was closed without drainage. The patient made a very prompt recovery and was able to go home in a week. He is now in good health and at his work as a plumber. In this case the lower lumbar lymph glands had evidently become diseased with tuberculosis from the inguinal. Suppuration occurred and the omentum, true to its functions, walled in the pus; but in so doing caused the obstruction. I think this must be rather a rare cause of intestinal obstruction, as I have seen no exactly similar case cited.

All of the above cases, which comprise all of the cases of intestinal obstruction upon which I have personally operated, recovered and are now in good health. I do not attribute this clean record of recoveries to any superior skill on my part, but to the fact that all of these cases were treated surgically before gangrene of the bowel had occurred.

Nearly every physician dreads a case of intestinal obstruction, and on account of this fear allows his judgment to be

obscured until he is forced into the diagnosis. Too often then the diagnosis does no good, for the patient is already moribund.

I believe that at least ninety per cent. of these cases would recover if the diagnosis was made as soon as it should be made by any careful man who has studied the symptoms and knows the subject. As a rule, the diagnosis is not hard to make, but the doctor often is tempted to postpone expressing his early convictions through sympathy for the patient and his family.

Certainly a surgical consultation should be called when obstruction is suspected.

The general death rate in this condition is very high, it is true. However, unnecessary delay is largely responsible for this high mortality. Mechanical obstruction which is not relieved surgically is almost certainly fatal. Even if an occasional abdomen was opened unnecessarily, this would be much better than to wait too long in a case of real mechanical obstruction.

Letter To The Editor.

To the Editor of the *Mississippi Medical Monthly:*—

Acknowledging receipt of your circular letter as secretary of the State Medical Association, I take advantage of your kindness in making me an associate editor of the *Monthly* to inflict upon a patient and long suffering profession in the state some more of my views anent matters bearing upon our common interest as physicians.

To begin: the medical practice act should not alone comprise the most admirable matter as set forth in your letter, but should by all means define in such plain English what the practice of medicine really is that even a Supreme Court could understand that it is something more than the mere giving of drugs.

It should also make it mandatory upon district and county attorneys to promtly prosecute all violators of this law upon request of the State Board of Health.

The State Board of Health would get its information at all times from local practitioners who would be cognizant of the facts.

For example, we have in our city to-day two unlicensed men who openly advertise to treat and cure such diseases as cancer, tumor, and in fact all kinds of disease.

I brought the matter to the attention of the district attorney, who referred me to the county attorney. This latter official is perfectly willing to prosecute these offenders, but wants me to make an affidavit against them. Now why should it be up to me, a private citizen, to be compelled to take part in the enforcement of laws that are supposedly made for the protection of the people generally and for which enforcement we have numerous paid attorneys?

If the people are not in favor of laws restricting the practice of the art and science of healing to qualified practitioners, why then it is either up to the medical profession to educate the public to the advisability of such laws, or else to simply let the whole thing drop.

To save my soul, I cannot see the sense of our spending time and money going before the legislature and urging laws to elevate the practice of medicine on the part of the regular school, while permitting any kind and form of quack under any name other than as a competent physician to practice.

I have yet to see one of these curers who did not sooner or later in some form or another resort to materia medica in treating their patients.

Even accepting that wonderful decision of our State Supreme Court that the practice of medicine means the giving of drugs, why they all violate the law.

Yet when a man who has devoted four or five years to the very hardest study in order to qualify himself for his life work presents himself for a license, he is made to stand an examination.

Now granted that he gets his license, and makes up his mind to locate in some city of the state, why he is more than apt to find from two to a half-dozen osteoquacks, or chiropracs, or some other fool humbuggery, each and every one of whom practices medicine and not a single one of them with any degree of responsibility whatsoever, either to the law or the patient.

Now all this is either right or wrong; if it is right let us shut up and permit the people to do just exactly as they please, but if it is wrong, why then let all get busy and get the right kind of laws passed, and then see that they are enforced.

H. M. Folkes.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

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The genius of Paul Ehrlich, after much travail, has brought forth a remedy which in the first flush of its birth was hailed as the weapon that, ready-made, was to conquer the dread black plague. Ehrlich, in giving it to the world, insisted upon several prerequisites to its use, namely: first, that it should only be used in cases where mercury and the iodides had failed; second, where the patient was retrograding instead of improving; third, that it should always be preceded by the Wasserman test and, lastly, it was not to be used until after a thorough physical examination of the various organs of the body. The great investigator, knowing only too well the fearful results following the introduction of various other beneficial remedies and their indiscriminate use and abuse, indeed hesitated for many months before putting this remedy in every one's hands. At last it was done, and what do we see? On every hand we hear of injections of Salvarsan; it is being used in leukemia, in psoriasis, in any and every condition with a cheerful disregard of its originator's urgent advice and remonstrance, as though these embryo surgeons had discovered it instead of Ehrlich himself. What will be the result of this dangerous and careless practice only the future can tell. The man who in his primeval innocence first distilled a stimulating drink out of his surplus grapes, little dreamed of the hell he was creating for generations that slept in the womb of time, and yet all the misery he created will be as but a grain of sand upon the seashore compared to a race whose body cells have been made arsenic-tolerant by the free use of Salvarsan. If it is only to be used after mercury and the iodides have failed, how criminal is it to use it in psoriasis and other skin lesions and so make the unfortunate, if he ever contracts syphilis, a hopelessly incurable case, whose prospect of cure has been taken away by being made tolerant to arsenic, and the festive spirochetae will find him a merry pasture. The spirit of Ehrlich may then

curse the day it was born. As practitioners of medicine it behooves us to be careful and not use to the patient's lasting ruin one of the greatest discoveries, properly used, of therapeutics. S. Myers.

Society Proceedings.

East Mississippi Four County Medical Society met in the court house at Okolona Tuesday, May 16th., at 3 P. M. Dr. Elkin in the chair. Dr. M. M. McMillan of Guntown reported in detail an abdominal section done in country practice ten years ago. Dr. F. J. Underwood read a paper on puerperal eclampsia. These papers were discussed by Drs. Bryan, Miller, Guinn and Beatty. Members present: Miller, Wicks, Goyer, Bryan, Brand, Green, McMillan, Donaldson, Banks, Elkin, Beatty, Guinn and Underwood. Visitor present: B. D. Hansell. F. J. Underwood.

Tri-County (Pike-Lincoln-Copiah) Medical Society met at Brookhaven June 6th. with the following members present: Arrington, Beacham, Butler, Dickerson, Flowers, Frizell, Higdon, Jones, Johnson, W. L. Little, E. S. Little, D. W. Magee, T. K. Magee, Purser. President Dampeer being absent, Vice-President Beacham took the chair. The general subject for discussion was gastro-enteric diseases of children. Dr. Frizell led with an excellent paper and was followed in the discussion by nearly all the doctors present. The committee on auxiliary legislation made a report showing that all the candidates for the legislature had been interviewed, and that all are favorable to the measures advocated by the Association. The secretary was instructed to write and ask for a written reply from each, stating his views on this matter. All the doctors were urged to keep these things in mind and try to get our representatives interested in them. Adjourned to meet at Brookhaven August 1st.
D. W. Jones.

As an argument to the farmer legislators for an increased appropriation for the State Board of Health quote Dr. Wood's article read before the Association in April: "In one county of this state there has been what may be termed an epidemic of hog measles, many hogs slaughtered, showing the presence of cysticerci cellulosae. A widespread microscopic examination, by detecting the tapeworm infection in man, would locate the original sources of infection and assist in checking a further loss in the hog industry."

Book Reviews.

COLLECTED PAPERS BY THE STAFF OF ST. MARY'S HOSPITAL, MAYO CLINIC, ROCHESTER, MINNESOTA, 1905-1909. Octavo of 668 pages, illustrated. W. B. Saunders Company, Philadelphia and London, 1911. Cloth, $5.50 net.

This is a collection of papers read before medical associations and contributed to medical journals by the staff of St. Mary's Hospital, Rochester, Minn., and gives, as it were, a birdseye view of the best work of the far-famed Mayo Clinic. The various essays include practically everything in hospital work from anesthetic and laboratory and operating room tecnic to Chas. Mayo's "Consideration of the Mortality in One Thousand Operations for Goiter." HOWARD.

A HANDBOOK OF PRACTICAL TREATMENT. In three volumes. By 79 eminent specialists. Edited by John H. Musser, M.D., Professor of Clinical Medicine, University of Pennsylvania; and A. O. J. Kelly, M.D., Assistant Professor of Medicine, University of Pennsylvania. Volume II. Octavo of 865 pages, illustrated. W. B. Saunders Company, Philadelphia and London, 1911. Per volume: Cloth, $6.00 net; Half Morocco, $7.50 net.

The second volume of this masterly work begins with a discussion of diseases of the cardio-vascular system by Sir Clifford Allbutt that is positively the last word on the subject in the light of our present knowledge. This is followed by an article on surgery of the heart by Clinton Dent M.C., F.R.C.S., and the remainder of the volume is taken up by the various infectious diseases and their complications and an article on animal parasites. Among the list of authors we recognize the familiar names of Lewellys Barker, James Carroll, de Schweinitz, Dyer of New Orleans—writing, of course, on leprosy, Hare, Chas. F. Martin, Rosenau, Schamberg and Stengel, a group of names that would attract the attention of any physician.

Of special note and interest are the articles on typhoid by Cole, on measles and scarlet fever by Weaver, on tuberculosis by Otis, on variola by Schamberg, on cerebro-spinal fever by Barker, on rheumatism by Stengel and on animal parasites by Riesman.

It is interesting to note that White and Wood, in the chapter on syphilis, are extremely, and we think wisely, conservative in their discussion of the widely heralded "606" and that they frankly advise that until we have further knowledge of its action "the general practitioner should follow the older methods of treatment."

The greatest criticism that the reviewer has to make of

the book is that Edward Martin, writing on gonococcic infection, takes entirely too cheerful a view of the possibilities of aborting fresh cases. True, his method certainly offers the best chances, but we respectfully submit that few gonorrhoeics are ever injected by their physicians "at intervals of two to four hours" for five days.

The press-work and illustrations are typical Saunders'.

HOWARD.

DIFFERENTIAL DIAGNOSIS. Presented through an Analysis of 383 cases. By Richard C. Cabot M.D., Assistant Professor of Clinical Medicine, Harvard Medical School. Octavo of 753 pages, illustrated. W. B. Saunders Company, Philadelphia and London, 1911. Cloth, $5.50 net.

This is rather a diagnostic clinic than a book on differential diagnosis and as such has both advantages and disadvantages.

After a few brief "general considerations" and a short chapter on pain, the author takes up the consideration of pain in the different parts of the body; as head, back, abdomen and its divisions, axilla, arms, legs and feet; and after commenting on the causes of pain in these localities, the diseases with which they are connected and the methods of examination, gives a series of case histories by way of illustration.

Fevers, chills, coma, convulsions, cough, weakness, vomiting, hematuria, dyspnea, jaundice and nervousness are similarly considered.

The text proper is well done, but of the case histories the comment may be made that the personal equation enters so much that the interpretation of some of them is difficult and that a student working on a patient with the aid of this book would be very apt to read himself into a wrong diagnosis by following histories that are misleading. This comment can be made of any similar book or collection of histories, which merely goes to show that this sort of teaching must be done in the clinics and cannot be done in the library.

HOWARD.

PRACTICAL MEDICINE SERIES, Vol. II. General Surgery. Edited by Jno. B. Murphy A.M., M.D., L.L.D. The Year Book Publishers, 180 N. Dearborn St., Chicago. Price $2.00.

We have frequently commented on the usefulness of these handy little abstracts of the year's literature, and the volume under consideration in no way detracts from the standard set by its predecessors. It contains an excellent compilation of the work done in surgery in the past twelve months and affords good means of "rubbing up" for those who are limited in the number of their periodicals. HOWARD.

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*INGUINAL HERNIA.

JOHN DARRINGTON M.D.,

YAZOO CITY.

When a medical association is large enough to have the meetings divided into sections, the members who are interested in any special branch attend that section, and thus all papers read before that section are of special interest to all present; but in an association such as ours, where we have only general meetings, it is a very difficult matter to present a paper on any branch and hope to interest all present; but the subject of hernia deserves the attention of both the surgeon and the general practitioner.

To the surgeon it is attractive because the operation for the radical cure is usually elective surgery, thus enabling the surgeon to operate under the most favorable conditions; it is attractive because it is clean surgery, and because his results are good; just how nearly perfect is dependent entirely upon the surgeon's anatomical knowledge, his judgment, his cleanliness, his technique and his ability to select suitable cases for operation and the suitable operation for the case.

To the family doctor hernia is of great interest, because it is one of the physical infirmities that he frequently meets in his general practice, and, from fitting trusses to relieving strangulated hernias, his interest is not allowed to wane.

When we think of the mechanical features of a human abdomen and remember the numerous openings required for the entrance and exit of the viscera, blood vessels and nerves, and that these openings are constantly subjected to an intra-abdominal pressure which is both hydrostatic and pneumatic, we are not surprised at the frequent occurrence of inguinal, femoral and umbilical herniae, and less frequently of the ventral, obturator, ischiatic, lumbar, pelvic, diaphragmatic, the retro-cecal, the duodenal, and through the foramen of Winslow; but we shall confine our discussion to the hernia of most frequent occurrence, which is the inguinal; this we divide into the oblique, or external variety, and the direct. Over eighty-

*Read before the Mississippi State Medical Association, 1911

five per cent. of all inguinal hernias belong in the former class, with the sac external to the deep epigastric artery. These cases are easy operations and recurrences are not frequent.

In 1889 Bassini published the technique of his operation for the radical cure of inguinal hernia, and it was immediately adopted by both American and European surgeons and is to-day the operation most frequently performed; though recently what is known as the simple anatomical operation—also called the Ferguson-Andrews-Girard operation—has proven its merit, and is the only rival of the Bassini method.

With the exception of those rare and unusual cases in which one of the various wire filigree operations may be indicated, the Bassini or the Ferguson operation meets all the indications and the results are most excellent.

The Bassini operation may be briefly described as follows: make the incision parallel to and about one inch above Poupart's ligament, this incision to extend from above the internal ring to the external ring, exposing the oponeurosis of the external oblique and the pillars of the external ring. The aponeurosis is split in the direction of its fibers and this opens the inguinal canal, and on further dissection of the external oblique, Poupart's canal is thoroughly exposed. The hernia sack, with the cord and fat, is now lifted and separated from the surrounding tissue, and the sack isolated and opened at the internal ring, which enables the operator to insert his finger into the sack and with a piece of moist gauze in the other hand he can rapidly isolate the sack. Reduce the contents of the sack and apply a ligature so high that when the sack is cut off it will retract well within the abdominal cavity and not leave a funnel-shaped depression of the peritoneum. The cord is pulled to one side out of the way and the internal oblique and conjoined tendon is carefully sutured to the exposed shelving edge of Poupart's ligament, great care being exercised that no injury occurs to the deep epigastric or iliac vessels; for this reason always insert the sutures through Poupart's ligament from below upwards, as this plan enables you to keep your eye on the point of the needle. These sutures, which should be chromic catgut, are tied without tension, being careful not to strangulate the cord with the upper or lower stitches. The cord is now laid upon this new floor and the aponeurosis of the external oblique sutured over it, and the skin wound closed.

The Ferguson operation is performed in the same manner except that the cord is not disturbed, which means that the external oblique when stitched to Poupart's ligament will be above the cord instead of below it.

These are clean cases and easy and it is ideal surgery and the mortality is so low that every case of hernia, if he is a good operative risk, should be advised by his family doctor to have an operation performed for the radical cure of the hernia.

Every case of hernia is taking a risk of strangulation occurring at any time and the risk is far greater than the risk of a carefully performed operation.

A strangulated hernia is a disaster, and only prompt and skilled treatment will save the patient's life.

The treatment is to reduce the hernia either by taxis or by operation.

Many of these cases if seen soon after the strangulation occurs can be reduced by taxis, but I wish to impress upon you the fact that taxis properly and judiciously executed requires as much skill as an operation and is by no means a simple, innocent procedure. It requires gentleness, patience and good judgment. Apply cold to the strangulated mass, thoroughly anesthetize the patient, elevate the hips and if necessary completely invert him by swinging him up by his heels. Do not try to push the contents of the sack back into the abdomen, but rather to pull it down and at the same time compress the mass firmly, keeping up the pressure for several minutes, and if the hernia is reducable it should give a gurgle or two and slip back into the abdominal cavity. If it does not go back, do not keep up your efforts for hours, as is sometimes done, but get him operated on at once, remembering that every minute's delay is diminishing his chances of recovery.

Some one has said "never let the sun rise or set on a strangulated hernia". It is a splendid rule but one often violated, and we are often called to operate after great damage has been done the constricted viscera, probably requiring a resection of bowel and a desperate fight for life, all of which could have been avoided by an operation a few hours sooner.

One out of every eight men over fifty years of age has a hernia, but it is not confined to men advanced in years, for both sexes and all ages are afflicted and these cases can be easily cured by an operation. You say there is some risk. That is true, though the mortality is practically nothing, yet death from those unavoidable complications, such as emboli, pneumonia and sepsis, still demands her toll. But remember this fact: more will finally die from strangulation than will die from operation, and the operation has in its favor the absence of the annoying truss and a lifetime of comfort to the patient.

The frequency of deaths from strangulation and the enormous number of trusses manufactured annually is strong evidence of our neglect in properly advising our hernia cases.

*CONSERVATIVE TREATMENT FOR ADVANCED CASES OF CARSINOMA UTERI.

J. W. BARKSDALE M.D.,

WINONA.

I wish to call your attention to a rather sadly neglected field of surgery, or rather gynecology, fraught with the highest possible menace to life and one which, as a general rule, we are prone to pass over, with the seemingly wide-spread belief in the ineffectiveness of remedial measures: carcinoma uteri in its later stages. No such misconception of our ability to cope with this ubiquitous malady exists during its early manifestations, but every surgeon and practitioner recognizes the fact that prompt ablation of the uterus and its appendages, together with as widespread dissection of the adjacent tissues as is permissible, will often completely eradicate the disease and, in a still larger percentage of cases, will give relief from suffering and freedom from any return for a varying period of years. Nor should these cases of advanced carcinoma come into the hands of the gynecologist save as a diminishing few. Slowly but surely is the dissemination of knowledge pertaining to gynecics in general, and this affection in particular, gaining ground among the laity chiefly through the earnest and honest efforts and teaching of the family practitioner until, let us hope, the time is not far distant when this scourge of womankind, with its classic symptoms, will cease to be regarded as a species of rejuvenation, beguiling the unsuspecting victim into a false sense of securtiy until the dictum "too late" has made her realize the fatality of her error. Notwithstanding that much has been done in the way of teaching as regards this affection, still we cannot be regarded as altogether blameless in the matter of its great prevalence. How often is the patient assured that the angry, inflamed laceration, or other pathological condition of the cervix, which but too frequently proves to be the direct forbear of this frightful offspring, is of trivial moment and demands no treatment, or, at most, merely some topical application to the uterus or other misdirected treatment, generally productive of more irritation than benefit?

In the preceding section we have had an able paper on this improper subject, dealing with it more *in extenso* than is my purpose, which is sufficiently indicated by the title, "Conservative Treatment For Advanced Cases Of Carcinoma Uteri". By advanced cases, I mean those unfit for radical operation—pan-

*Read before the Mississippi State Medical Association, 1911.

hysterectomy—by reason of implication of adjacent tissues and organs to such an extent that they are surgically irremovable, metastasis or other cause, for I would not be misconstrued into advocating the procedure presently to be outlined as in any way infringing on that class of cases capable of being benefited by radical operation, which has yielded results so gratifying and which will probably never be superseded by operations of lesser degree. For these cases, however, which we have been accustomed to consider as without the pale of operative relief, and which we have turned away from the "door of hope" without an effort to reach forth to them a helping hand, I would unhesitatingly and unqualifiedly advocate the Byrne method of treatment, or some modification of his method. This distinguished pioneer in this particular line of work operated on three hundred and sixty-seven cases of carcinoma uteri during a period of thirty years without an operative death, and the magnificent results achieved can be best illustrated by showing something of their subsequent histories. I quote from Kelly and Noble: "Byrne's experience covers three hundred and sixty-seven cases, extending over a period of thirty years, without a single operative death: one hundred and forty of these were carcinoma of the cervix, in two hundred and nineteen cases both cervix and body were involved, and in only eight cases was the disease confined to the corpus uteri; one hundred and fifty-one cases were lost sight of during the first year; there remained, therefore, two hundred and sixteen cases of which the subsequent history is known. Of these, nineteen remained free from the disease from ten to eighteen years, twenty-two for five years or more and ninety-three for two years or more. Thus, nineteen per cent. were free from recurrences for five years or more and over forty-three per cent. for two years and over." Byrne, however, was an enthusiast with reference to his work and due allowance must be made for the incipient cases operated as well as those with late manifestations, and I doubt not that for early cases classical operation would show an even less percentage of recurrences than did his series, though likely to carry a slight initial mortality. During his whole career, Byrne inveighed against mutilating operations for uterine cancer with such persistence and to such an extreme that it is likely that the very force with which he advocated his method and the spirit of antagonism he displayed, were, more than any others, the reasons for its long delayed acceptance. Lomer said of him: "Byrne reminds me of a preacher in the desert, who repeatedly and persistently proclaims well-known truths without being heard."

The essentials of his method consist in destroying, as thoroughly as possible, all diseased tissues by means of the galvano-

cautery, the curettage of carcinomatous masses from the cervix or within the uterine cavity and amputation of the cervix by means of a wire loop. I should say that, judging from my own experience, there is no particular technic or any well defined series of steps to be followed. Each case stands upon its own pathological footing and must be treated accordingly. Byrne thought that the galvano-cautery possessed some distinct advantage over the thermo-cautery; by reason of his greater familiarity with the galvano-cautery it may have possessed an advantage in his hands, but it is likely that equal results can be obtained from either one.

In well advanced cases, where the cervix is the seat of a cauliflower growth, bleeding on the slighest provocation and productive of an ichorous, offensive discharge, with evidences of systemic intoxication, the change in the picture after thorough cauterization is astonishing. The method requires no high degree of operative skill, though, of course, great care must be taken to avoid injuring the bladder or other important structures by reason of the extreme heat. I had not seen a complete description of the method when I first practiced it and neglected to sufficiently protect the anterior vaginal wall, with a vesico-vaginal fistula as a result. Briefly, the steps of the operation, in a general way, may be said to consist of thoroughly curetting away all diseased tissue, amputation of as much of the cervix as is possible with the cautery knife at a dull-red heat and thoroughly charring the uterine cavity. It is theorized that the carcinoma cells have not the resisting power to heat that is possessed by the normal tissues, and that a degree of heat that will be withstood by the latter will destroy the cancerous elements. Be that as it may, the freedom from recurrences *in loco* is wonderful. With reference to this point Bydne says: "I have never known of an instance of relapse in which the disease has returned to the part from which it had originally been exercised. I have repeatedly observed the reappearance in the fundus, ovaries and some of the adjacent tissues, but I have never known a single instance in which the disease has reappeared on or very close to the cauterized surface from which the cervix has been removed by galvano-cautery."

Unless the vaginal wall is burned from the propinquity of the cautery, there is practical freedom from pain following. To guard against this, I use four retractors, one applied to each anterior and posterior vaginal surface and one to each lateral wall. This possesses the added advantage of bringing the whole operative field into clear view and safeguards the patient from the formation of fistulae. In using the knife cautery, care should be taken not to have it at too great a degree of heat, else considerable hemorrhage will follow. The instrument

should be at a dull-red heat for cutting, which should be done slowly. Following the procedure outlined above, there is of course some pus production, and the wound area fills in slowly by granulation.

I must confess to my great skepticism as to the efficacy of this procedure on first using it. I had, however, within the preceding month, seen two cases, inoperable from a radical point of view and this one, coming so shortly after, determined me to give it a trial. The case was in every sense inoperable, so far as any cutting operation went, yet to-day, one year later, the woman is in seemingly good health, having gained thirty-five or forty pounds, with complete freedom from hemorrhage, local recurrence or other carcinomatous manifestation.

The length of my experience with this method will not enable me to present any statistics of value as to the average prolongation of life. Since the case mentioned above, I have had four others, with like results, and believe that but for this measure, all save the last, operated about a month ago, would have succumbed before this. Certainly if we can prolong life for only a year or so in this class of cases, we have done a great work when we consider their hopelessness for relief from other sources, for, according to Kelly, the recurrence is generally in the adjacent pelvic tissues and death usually takes place from uraemia or exhaustion with comparative freedom from pain or other usual accompaniments of carcinoma. Every one of these cases operated upon is practically a restoration from the grave and I am convinced that a trial at your hands will yield the most gratifying results.

*DIAGNOSIS AND TREATMENT OF CHRONIC AFFECTIONS OF THE HIP.

WILLIS C. CAMPBELL M.D.,

MEMPHIS, TENN.

The hip is the most deep-seated and least accessible of any of the larger points, and requires a minute understanding of the anatomy to appreciate fully its physiology and pathology. Time will not permit a full discussion of each lesion, but it is my purpose to point out briefly some important factors in the diagnosis and treatment of chronic affections of this joint.

We have departed from the old adage "Given a chronic joint affection in a child, Tuberculosis", though it is quite rare that I see any long-continued disturbance in either children or adults that someone has not suggested "Hip disease". Truly

* Read before the Mississippi State Medical Association, 1911.

tuberculosis is responsible for a large per cent. of joint diseases, and is characterized by a symptom complex well described in text-books on orthopedic surgery as follows: Onset insidious, pain referred to inner aspect of knee, "night cries", atrophy rapid, attitude of limb in early stage held in flexion, abduction and external rotation, range of motion limited by spasm of muscles, but there are a few practical observations, not included in the usual list of symptoms, which have been of aid in doubtful cases. Limitation of internal rotation is often perceptible before other motions are affected, and if internal rotation is free diagnosis should be guarded regardless of other symptoms. The skin over the anterior aspect of the thigh may be slightly thickened as compared with that of the normal side.

The X-ray may be of assistance in doubtful cases, and should always be used, but we cannot depend absolutely on a skiagram if negative. The skin and eye tests with tuberculin are worthless in suspected joints. The old injection method will give a local reaction in the joint involved, but is not without danger, and should be reserved for those cases where much doubt exists.

From personal observation of a large number of cases treated at various clinics, the Lorenz short plaster spica, properly applied, gives less abscesses and better results than the old traction splint. However, there should be no routine treatment for all cases, various methods being applicable to special conditions. Fresh air and hygienic measures are essential as in any tubercular process. Conclusions regarding the tuberculin treatment are at variance, while Marmorek's serum, prepared from the tubercle baccillus by the same method as diphtheria antitoxin, and administered by rectum is said by Freiberg of Cincinnati to be of advantage, but its enormous expense prohibits is use. I am now using autogenous vaccines in old tubercular abscesses, but it is too early to give a conclusive report.

Osteoarthritis, a type of arthritis deformans, is often monarticular, and the hip is a frequent seat. Motion is limited, but the resistance differs materially from the sudden muscular spasm of a tubercular joint, being a solid mechanical obstruction to the range of motion from the proliferation of bone in and about the joint. It is not infrequent that the formation of "osteophytes" as the new bone is called, is so distributed that all motion is impossible except flexion, and the joint is converted from a ball and socket to that of the hinge variety. On passive motion a sensation of crepitus can usually be detected, but as the same is present in villous arthritis and other conditions this sign, alone, has little diagnostic value. Indiges-

tion is so frequently a concomitant symptom as to suggest a casual relation. Dietetic and eliminative treatment is rational, while local measures as vibration and hot air baking are useful adjuncts. When pain on motion from existing osetophytes is present all treatment may prove futile, and operative procedures the only resort, which may be done by opening the joint and removing the offending osteophytes, but these are liable to reappear, or by removal of upper surface of head and corresponding portion of acetabulum according to Albee, causing a firm bony ankylosis with relief of pain. And it is surprising how little inconvenience the patient finds from one ankylosed hip, as the opposite joint and lumbar spine compensate to a great degree the loss of motion.

In this connection "rheumatism" might be mentioned, which with malaria is the scapegoat of so many bodily evils. In the light of recent knowledge "rheumatism" as a clinical disease does not exist but manifestations in the joint, so familiar to all, are due to absorption from the intestinal tract, infected tonsils, generative organs or other remote foci- which should be called "infectious arthritis". But years of usage makes it difficult to discard from our nomenclature a term so descriptive of a symptom. The condition is seldom if ever confined to a single joint, two or more being affected in varying degrees. Salicylates are of no value except to allay pain, and cause digestive disturbances. The sources of infection should be carefully sought and when found eradicated.

The angle normally existing between the neck of the femur and its shaft ranges from 120 to 140° F. Any decrease in this angle causes a condition known as Coxa Vara, producing characteristic signs that for many years were considered mild tuberculosis, though the phenomena was classically described by Roser as early as 1848. The cause is either metabolic softening of the neck, which readily yields under the superincumbent weight received on its oblique axis, or ununited epiphyseal fracture may bring about the same state of affairs. Puberty is the most frequent age of occurrence, and the general bodily change at this period may have its influence as a causitive agent. The symptoms may be best illustrated by the history of a typical case. C. D., male, age fifteen, weight one hundred and eighty-nine pounds, five feet five inches in height, had several falls but could not accurately date disturbance to any. December 1909 was unable to carry out school gymnastics, and school inspector was consulted, but could find nothing abnormal by casual examination. In July 1910 the condition had become gradually worse, when family physician was called. In October the case was referred to me. The attitude of the limb was external

rotation, atrophy one inch in thigh, shortening one inch. Abduction and internal rotation markedly limited, flexion and hyperextention slightly limited, external rotation and adduction free. Trochanter three-fourths inch above Nelaton's line. Diagnosis coxa vara, which was confirmed by the accompanying skiagram.

The treatment has been plaster spica in forced abduction, and later brace to partially remove weight from already depressed neck. My last observation was made March 31st., and conditions were unchanged, which is all that could be desired from non-operative treatment. If at the termination of one year there is still no further change we may conclude that the bone is sufficiently hardened for operation, which should restore perfect function. A subcutaneous osteotomy is done at the level of the lesser trochanter, after which the limb is abducted and rotated inward to restore the normal angle of the femur, and correct the limited abduction and internal rotation. A cast applied from toes to nipple line holds the part in position until fracture heals.

Ununited fractures of the neck of the femur are of common occurrence after traction with weight and pulley or other irrational method. Sir Astley Cooper stated in 1834 that fractures of the neck of the femur usually united by fibrous union, since which the general opinion has prevailed that such was the best that nature could do. As late as 1902 Bennett, another English surgeon observed in speaking of this fracture "that bony union does not occur".

About March 1st. an old lady came to me, who had two years previously while in Venice fallen from one step to the pavement, striking over the left trochanter, and according to the attending physician and surgeon sustained a fracture of the neck of the femur. After several weeks she was told that the union was firm, notwithstanding pain and inability to bear weight on the injured part. During the two years that ensued she consulted surgeons in Europe and America, but was given little encouragement, and finally drifted into the hands of Christian scientists and quacks. She is a thin, nervous woman, the left lower extremity is rotated outward, atrophy of entire extremity, trochanter one and one-half inches above Nelaton's line, which is a line drawn from the anterior spinous process to the tuberosity of the ischium, and under normal conditions the trochanter is below this point. Shortening one and one-half inches. Motion painful, decidedly limited in abduction and to some extent in all directions. Little can be done by braces or mechanical measures for such a case. If general health permitted, open operation offers best results. Consider-

ing the mechanism of such a fracture, one can readily see the cause of poor results by this old method. When the break occurs the trochanter is displaced upward by the gluteus maximus, which is attached to its external surface, while the external rotators, being more powerful than those of internal rotation, the limb is turned outward as indicated by the position of the foot, pointing the broken neck in continuity with the trochanter forward or forward and inward, separating the raw surfaces. To reduce the displaced fragments we must first make traction to overcome the action of the gluteal muscles, secondly, abduction and internal rotation, which obviously places the fragments in apposition, and healing occurs with firm bony union as in any of the long bones. A plaster spica applied from toes to nipple line holds the part in the desired position until union takes place.

In January I treated a similar fracture of four weeks' duration, in a man aged fifty-six. Competent physicians had found sugar and albumen which contraindicated open operation, the X-ray showed no effort at union and considerable displacement. The patient was thoroughly anesthethized and the limb manipulated in all directions to break down any adhesions in a faulty position, then traction made with abduction and internal rotation, while plaster cast was applied as above described. After seven weeks the cast was removed, and there was evidence of perfect union.

Pain from sacro-iliac displacement frequently radiates down the sciatic nerve and into the hip and knee, rendering diagnosis from hip lesions occasionally difficult, as in case of a lady aged forty, who had suffered for years, and at times was unable to walk. When first seen she had been treated by massage and other local measures for weeks with no abatement of symptoms. After examination and an X-ray picture to show that the hip was clear, she was placed on an apparatus which I use for applying certain types of plaster jackets and firm pressure made over the upper end of the sacrum by pads of felt. In this position a plaster jacket was applied extending well down on the painful thigh. Immediately she was able to bear her weight without pain, and returned home for three weeks. At the end of this period, there being no further symptoms, a brace was applied which prevented recurrence. Since she has been in perfect health without the slightest annoyance from her former complaint.

The X-ray is invaluable in joint surgery, but should not be depended upon alone. Each case requires a careful study of the general condition of the patient, as well as the impaired joint itself. If you are not fully conversant with the processes

taking place in the joint very little can be expected from a skiagram.

The points which I desire especially to emphasize are:

(1) If internal rotation of the hip is free and unlimited, doubtful diagnosis of joint tuberculosis should be made regardless of other symptoms.

(2) "Rheumatism" is not a clinical disease, but a symptom of remote infection from various sources.

(3) Osteoarthritis is a common monarticular affection of the hip. If intractable with pain on motion only operative procedures will give relief.

(4) Coxa vara, a mechanical condition, so often considered tubercular, may be overcome by osteotomy of the femur.

(5) Poor results in fractures of the neck of the femur can be avoided by rational procedures at the time of the injury.

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*SOME UNAVOIDABLE POSTOPERATIVE COMPLICATIONS.

J. A. CRISLER M.D.,

MEMPHIS, TENN.

The postoperative sequelae sometimes arise most unexpectedly and without the least apparent provocation. That fact will always render the outcome of any surgical undertaking slightly speculative. No matter how thoroughly painstaking we are and how perfect our technique in all particulars, very occasionally and rarely our mortality list will be increased by some one of these postoperative features that could not be foreseen or foretold. The two important ones over which we seem to have no right to hope for absolute control are ileus and acute dilatation of the stomach. It is to these two conditions that I will call your attention, for they figure more darkly into the unavoidable postoperative complications than all the others combined.

I, of course, do not consider hemorrhage as an unavoidable occurrence, but on the other hand I am inclined to class that as an inexcusable one, in the large majority of cases. While I feel this way about it, I am yet quite positive that postoperative hemorrhage is the cause of more deaths than either ileus or acute dilatation of the stomach. If postoperative hemorrhage is avoidable, as I believe it is, it does not come up for consideration under the caption of this paper. The unavoidable things are the ones that give us our undeserved mortality. Take dilatation of the stomach for instance. Here you are overtaken without any warning or premonitory symptoms whatever by

*Read before the Mississippi State Medical Association, 1911.

one of the most intractible, hidden and dangerous adversaries that we can ever encounter. We are brought immediately face to face with a condition that we not only could not have anticipated or foretold by any manner of signs or symptoms, but worse than all we are utterly unable to diagnose the condition in the vast majority of cases. Surely acute dilatation of the stomach is one of the most bewildering, confounding and desperate conditions that we can be called upon to combat. I doubt if anybody has a right to speak with authority upon the subject. No clinician has ever pointed out the danger signs whereby we might save our patient from the horrors of it.

You may leave your patient one hour in apparently a satisfactory condition and in the next you may find an almost moribund state. Let us not conjure ourselves into the belief that we can diagnose an acute dilatation of the stomach very often in a lifetime and we might as well remember that our remedial agents for combating the conditions are, in most cases, absolutely useless.

From what I have said I have led you to believe that actue dilitation of the stomach has no premonitory symptoms and cannot ordinarily be diagnosed and that treatment is practically invalid. This may be exaggerated some, but it is not very far from the real truth. In all of my experience in surgery, I have never been able to positively diagnose but one case.

As so little is known of the condition, I deem it will not be amiss to recite the case to you in detail and in doing so I am not courting any favorable criticism upon my diagnosis and treatment, nor any compliments upon the favorable termination of the case. While I was deep in the mire with it and fought as best I could, and while the patient recovered, it may be the termination would have been just as favorable had I not turned my hand to the aid of the patient in the slightest degree. The case was:

Mrs. Charles R. B., Hunter, Ark., age about thirty-four, family history negative, had always had a bad stomach, suffered with a great deal of indigestion and had occasional attacks of acute biliary colic for the past few years. Had pain in the right gall-bladder region and while not distinctly jaundiced had a peculiar discoloration of the skin and muddy conjunctiva. Tongue coated, pulse very good, no temperature. Has tenderness on pressure over the gall-bladder region and some tenderness over the epigastrium upon deep pressure. Abdomen flat and patient thin. Blood examination negative, urine examination negative. Patient was placed in the Presbyterian Hospital October 6th. 1909 and the usual preparations made for an operation, which was done October 8th.

The incision was made in the right rectus muscle and an examination was made of the stomach and duodenum, but no pathology was found in this organ beyond a tendency to a general ptosis of all of the abdominal viscera. The head of the pancreas was somewhat enlarged and hardened. There was no stone in the common or hepatic or cystic ducts. The gall-bladder contained one large stone about the size of a walnut and a lot of clear, thick mucus and some pus and bile. The usual drainage was instituted and the abdominal incision closed in the regulation manner. The patient experienced as little trouble following the operation as could be wished for. She suffered very little from nausea and had but little inconvenience from gaseous distention in the intestines. On the tenth day she was able to be propped up in bed and was as bright and cheerful and happy as could be desired. About two o'clock that night she began to complain with a distressing fulness in the epigastrium. The nurse's record showed a marked increase in the pulse rate, so that within a few hours she had departed from the normal into a condition of profound shock and impending death. When I saw her the following morning early, I was astonished at her critical condition. She was practically in a dying state. Her pulse was too fast and feeble to be counted. She was bathed all over the body in a cold, clammy sweat and her death-like pallor was most marked. Out of the gall-bladder there had flowed what appeared to be several gallons of a brownish fluid and although the nurse had changed the dressings many times these few hours the bed had become perfectly saturated with this fluid that had escaped through the gall-bladder wound. In removing the dressing the outpour of the fluid through the wound was so pronounced that a pus basin full could be caught within a few minutes. There was, in addition to this, considerable distention over the entire upper abdomen to such an extent as to greatly embarass the respiration, which was fast and shallow. The patient was listless and could not speak above a whisper. My diagnosis was acute dilatation of the stomach and was based largely upon the outflowing of brownish acid liquid in such enormous quantities as could not be accounted for in any other way, except coming from the stomach, passing for a short distance down the duodenum and then a process of distension had found its way up the common duct and out the cystic duct to the outside world. About this time one of my colleagues saw the case and remarked that the patient was dying and that nothing could be done. I mention this to show the evident desperate condition.

Aided by my assistant, I introduced a stomach pump and relieved the stomach of a large quantity of the same kind of

brownish-looking fluid as was flowing out of the gall-bladder. We were all surprised at the immense quantity that was in this way drawn off, but did not make an accurate measurement of it. This afforded temporary relief to the distended condition and to the respiration and there was an apparent cessation of the outflow at the gall-bladder wound, but this was soon resumed until it looked to me like, and I remarked upon the fact, that our patient would be absolutely drained of every fluid in her body, unless this waste could be stopped. We now all agreed that the case was one of acute dilatation of the stomach and that the waste was coming from the stomach through the gall-bladder, but this did not in any manner help the situation, so we decided to replace as much fluid or more as was escaping. Our patient was thirsty, with a stomach full of fluid and nauseated, yet the more she vomited the more she had to spare. The foot of the bed was now elevated about three feet high. Slow rectal salines were begun and in addition to this I introduced two quarts of normal saline with twenty drops of adrenalin directly into the vein. This made the pulse countable and seemed to improve the general condition somewhat, but not for very long, as one hour later the pulse had again disappeared. I now began subacutaneous instillation of large quantities of saline solution, beginning under both breasts. During the next twenty hours, four or five gallons of normal saline had been taken up through the subcutaneous tissue and rectal instillation. At the end of this time it was thought that the patient showed slight improvement. That is to say, she was more rational and alert and there was some volume to the pulse and it could be counted in the neighborhood of a hundred and eighty and was decidedly more regular. The respiration was considerably relieved and the excessive perspiration had cleared and the pupils had become normally contracted from their dilatation. The flow from the gall-bladder was less and the distention of the stomach apparently greatly relieved. Hypodermics of strychnine that had been given from the beginning of this attack were discontinued because they appeared to do no good and a grain of spartine sulphate was substituted and given hypodermatically every three hours for the next twenty-four hours. At the end of this time the patient was perceptibly improved in all particulars. The pallor had almost entirely disappeared, there was some color to the lips, the pulse was now about a hundred and respiration normal. The patient did not have any further trouble beyond the fact that wherever this fluid had escaped from the gall-bladder and had been most abundant the skin was blistered.

To recapitulate: the obstruction to the outlet of the stomach contents occurred somewhat below that part of the duode-

num in to which the common duct empties and the outflow, regardless of valves in the ducts, was most positive and abundant. The elevation of the foot of the bed was done in order to combat the shock and relieve the cerebral anemia and not with any knowledge at that time of any direct mechanical benefit to the stomach itself. The enormous quantities of salines given and the methods employed seemed necessary on account of the excessive and inexplicable waste of fluids, which threatened to terminate life and leave the patient withered and dry. The stomach lavage was done in order to relieve the stomach of its gaseous and liquid distention. Wherever any one of these agents were definitely beneficial, I cannot say, but it was thought by my assistant, Dr. J. A. Vaughan and by the head nurse, Miss Buford, both of whom rendered me valuable aid, that the position of the bed and the salines had pronounced beneficial effects.

A recent letter from the patient, Mrs. Brinneman, states that she is enjoying most excellent health and has never had a symptom of a return of this most unpleasant experience.

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*SOME UNUSAL SYMPTOMS IN MALARIA.

B. F. McNEAL M.D.,

EZRA.

In bringing before you the subject of unusual symptoms in malaria it is not without a keen sense of my own limitations and insufficient experience and observation, nor am I unmindful of the imperfections and the fragmentary character of my paper. In fact, I have selected only a small fraction of what might have been a very large subject, a few symptoms of the great subject malaria, and offer you only a few fragments from actual country practice in the Yazoo Delta, or "swamp", and without the microscope at that. I realize, therefore, the possibility of some adverse criticism from the scientific side. But in each case that I shall mention to you the diagnosis was confirmed by the therapeutic test, two by another physician also.

The subject of this paper, please remember, is not malaria, nor its diagnosis nor treatment, but symptoms in malaria, and these restricted to unusual symptoms which seem likely to perplex or mislead a physician of little experience.

Hemoglobinuria is so common in our section of the country as to be excluded from this paper, coma or stupor with high fever is fairly common, subnormal temperature during part of

*Read before the Mississippi State Medical Association, 1911.

a malarial attack is not rare, the deadly pernicious congestive chill fortunately is less common with us; but all these are so well known as rarely to mislead the experienced physician who is on the alert.

I shall call your attention, then, to a few patients, each presenting an unusual symptom or two.

The first case was that of a negro man about thirty-three years of age who came to me for the treatment of the one symptom, nettle rash, and complained of nothing else. But inquiry elicited the fact that it had recurred on alternate days at regular intervals for several times, growing worse and more extensive each time until it covered his whole person, each attack gradually disappearing after a few hours, with the onset of a slight fever. Promptly relieved by quinine and purgative.

The second case was a white man, thirty-one years of age, suffering from a severe cramping pain in the region of the pancreas and stomach, so severe that he could neither lie down nor stand up, but was compelled to sit in a semi-recumbent position in a chair. My first thought was of appendicitis and the next gall stone, but neither of these regions showed any signs of involvement. Inflammation of the pancreas and possibly of the stomach then suggested itself, which I now believe to have been correct; but as to the cause, I was for the time nonplussed. Dr. J. S. McNeal, my brother and partner, was called in the next day and, from the foregoing symptom, coupled with light fever, slightly enlarged and tender spleen, made the diagnosis of malaria, gave twelve grains of quinine sulphate in acid solution, to be repeated three times a day for two or three days, and the patient recovered promptly.

The third case and one of the most interesting to me, was a young white man twenty-four years of age, whom I was called to see in consultation with Dr. Wm. E. Richards of Inverness. This patient had cramping pains, beginning somewhere in the region of the stomach and gradually extending to all parts of the body and extremities, recurring on alternate days at first, then daily, and growing worse with each attack until almost deathlike in severity, even the facial muscles and the tongue contracting so rigidly that speech was impossible in the height of the last and most severe paroxysm, which occurred the day before I saw him. These symptoms were in the culmination of a chronic cease of malaria. The patient had been under occasional observation of a competent physician several months. Sufficient other symptoms were present to make the diagnosis clear: regular periodicity, fever, occasional dumb chills, enlarged spleen, etc. A peculiar symptom in the early history of this case was "morning sickness" with vomiting, after which he would go ahead with his work comfort-

ably for the rest of the day. The diagnosis of malaria was readily reached by each and both of us, ten grains quinine in acid solution given, followed by smaller doses. The patient recovered without another paroxysm, and has gained nineteen pounds in weight in a few months.

My brother, Dr. A. W. McNeal of Money, Miss., reports a case somewhat similar to my first, except that the eruption was scarlatinal in appearance and fever much higher than in the case of nettle rash.

Dr. S. L. Brister of Greenwood has very greatly aided and obliged me by the following reports of some of his "unusual" cases:

"Annie M., age sixteen mulatto, nurse. Gave only history of slight sore throat and headache for two days. Family history good. Examination showed some evidence of malaria. The lady employing her said this was impossible as there were no mosquitoes in the house; but a close search revealed mosquitoes then present. Gave purgative and commenced quinine. Called five hours later and found her only semi-conscious, extremities cold, pulse seventy-eight, temperature 101° F., muscular rigidity all over the body and especially of arms and thumbs, which could not be straightened even by force. Diagnosis—pernicious malaria, algid form. Gave one-fourth grain morphine sulphate and nine grains quinin bimuriate at once hypodermically, and continued quinin bimuriate, five grains per mouth, until thirty more grains were given. At nine o'clock in the forenoon next day the patient was free of fever and recovered without any other treatment."

"Edward McN., age ten, white, October 20th. 1910. History of having three chills of quotidian type. Saw him at three o'clock in afternoon. Excessive vomiting—bile. Temperature 101° F., pulse one hundred and twenty, respiration sighing and somewhat of Cheyne-Stokes variety, flexor muscles of forearms contracted, especially of thumbs. Gave quinin bimuriate, five grains hypodermically, and followed with three grains every four hours until twenty-four grains were given."

"Edward C., age sixteen, colored. October 27th. 1910. Saw him at seven o'clock in the morning, lying on the floor and totally unconscious. Muscular rigidity all over the body. Jaws locked. Pulse one hundred and twenty. Temperature not accurately taken. History from family that was feeling bad the day before but worked all day. Called in the morning at five to make a fire; he got up and fell in floor in a convulsion. Gave quinin bimuriate hypodermically at seven, twelve and six o'clock October 27th. Consciousness regained after thirty hours Bowels opened at the time with castor oil, quinin muriate given by mouth. Relieved promptly."

MISSISSIPPI MEDICAL MONTHLY.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

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Last month we called attention to the dangers that will follow the indiscriminate and injudicious use of Salvarsan, or 606, dangers which the discoverer pointed out in no uncertain tones and which are being disregarded in every American town and and village by embryo surgeons who do not hesitate to use it in primary syphilis, a condition above all in which it should never be used and to which it is entirely unsuited by every therapeutic consideration. As though the warnings against the unreasoning use of this potent and, in the proper sphere, valuable therapeutic agent, were insufficient, we quote a recent utterance of the greatest living syphilographer, Sir Jonathan Hutchinson, than whom no living man has had greater experience in treating this black plague. Writing in reference to the treatment of syphilis by arsenic, Sir Jonathan calls attention to the increasing development of cancer among those who have taken arsenic continuously and in ordinary dosage. He has seen it occur so often that he has discontinued entirely the use of arsenic in syphilis and points out the additional danger with an arsenic preparation like Salvarsan. Finally he concludes by saying that he has seen no results with Salvarsan that could not be achieved by mercury and the iodides if boldly used. This warning by the greatest living authority on the subject ought to make us pause before injecting into our patients a substance, potent for good and how potent for evil only the future can tell. We should all bear in mind Ehrlich's dictum that Salvarsan should only be used in those malignant cases of syphilis, which are retrograding and not responsive to the action of mercury and the iodides, and then only after a careful physical examination excluding visceral disease. How often these directions are ignored is known to all and the penalty unfortunately will be paid by the poor patient and not by his surgeon.

S. Myers.

Book Reviews.

THE PRACTICAL MEDICINE SERIES, 1911. Vol. III. The Eye, Ear, Nose and Throat. Edited by Casey A. Wood C.M., M.D., D. C.L.; A. H. Andrews M.D.; G. P. Head M.D.

As usual this small volume is found full of very good abstracts of the year's most important articles and will be found a very useful book to read carefully and have at hand for reference.

M. H. Bell.

ESSENTIALS OF OPHTHALMOLOGY. W. S. Sims M.D., Tucker Printing House, Jackson, Miss.

An outline of twenty lectures on diseases of the eye, intended for use by students of medicine.

M. H. Bell.

DIAGNOSTIC AND THERAPEUTIC TECHNIC. By Albett S. Morrow M.D., Adjunct Professor of Surgery, New York Polyclinic. Octavo of 850 pages, with 815 original line drawings. W. B. Saunders Company, Philadelphia and London; 1911. Cloth, $5.00 net.

Though containing much valuable information concerning therapeutic tecnic, this book is especially valuable for its thorough treatment of diagnostic methods and though many, if not all, of these can be found elsewhere the reviewer has not seen any similar collection. It is a great convenience to be able to lay one's hand on information of this sort on short notice instead of having to prowl through a whole shelf-full of books in search of it and we feel sure that this convenience will be appreciated. While excellent for a student it is of infinitely more value to the man who has been in practice for some years and whose memory of some diagnostic method has been obscured by a lack of cases needing that particular sort of an examination. To such men we cordially recommend the book. They will find it a great help.

Howard.

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SURGICAL AND RECTAL DISEASES

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TREATMENT OF APPENDICITIS BY HYPODERMATIC INJECTION OF COLON BACTERIA.

H. M. FOLKES M.D.,

BILOXI.

Having recently had a most interesting experience with a case of appendicitis in which operation was declined, I deem it incumbent upon me to call the attention of the profession to what seemed a very prompt response to treatment, so that others may investigate and test the procedure *in extenso.*

Beulah D., aged ten, weight eighty-five pounds. Family and personal history good.

Had slight attack of appendicitis in summer of 1910, it being unrecognized as such however, until diagnosis made in present attack, when similar symptoms were recalled by mother as having then existed.

On afternoon of May 2nd. 1911 patient, then apparently well, ate excessively of peanut candy.

On morning of 3rd. went to school as usual, feeling well, but was compelled to return home about noon suffering with nausea, vomiting, fever and pain in abdomen.

Her mother at once gave her a large dose of castor oil which cleaned the bowels thoroughly that night.

I was summoned on morning of the 4th. and found the child with a typical case of appendicitis presenting the following symptoms: tumor as large as a lemon at McBurney's point, marked rigidity, tenderness, pain, nausea, temperature 101.8° F., pulse 130.

Immediate operation was advised but declined.

Ice cap was ordered applied over tumor, and strict orders given that absolutely nothing be permitted to pass the patient's lips until further orders.

This procedure was followed for thirty hours, at which time pulse was 148, temperature 101.6° F., pain had subsided, nausea vanished and the patient was comfortable.

On morning of the 6th. patient was allowed cracked ice in small quantities at three hour intervals.

Small quantities of water next day, and on the following morning temperature showed 98.6° F. and pulse 90.

Strained soup in two ounce quantity at two hour intervals was then given.

From this time on the patient made rapid progress towards recovery, the temperature being normal, pulse 88, no pain or soreness though tumor still was present, showing a size of about that of an English walnut.

Diet had been restricted to small quantities of buttermilk, clear soup, water or cracked ice at two hour intervals.

On the morning of the 11th., eight days after onset of attack, with condition as outlined above, temperature suddenly went to 100° F. and pulse to 108.

Upon examination, tumor was found to have again enlarged to even greater dimension than when first seen, showing at this time a size equal to that of a medium orange, while the facial expression was clearly indicative of acute abdominal involvement.

Operation was again advised, to be again refused.

It might be well here to explain why operation was so strenuously declined. Some sixteen years previously, a daughter of about the same age as this present patient had appendicitis, was operated upon and died. The parents in consequence felt, however unnecessarily, that similar consequences would probably follow operation in this case.

Consultation was asked for, but declined, as parents stated that they had full confidence in reporter and that consultation would simply mean further urging of surgical intervention.

Within the following thirty hours temperature had gone to 102° F., pulse 120.

Thinking that possibly the infection was due to colon bacilli, and not being permitted to operate, I concluded to try an injection of colon bacteria which I did by giving 200,000,000.

Within twenty-four hours the temperature had gone to normal, pulse 102, facial expression natural, patient comfortable.

No food had been permitted since the return of the fever, nor had any medication been attempted.

During the following three days only cracked ice, water and clear soup had been permitted.

At the end of this time temperature had continued normal and pulse had become so.

The tumor, *pari passu*, become smaller and smaller and now, ten days after the injection, it has entirely disappeared.

The patient other than being thinner than before the at-

tack is as well as ever, though I have advised her parents to have an interval operation done.

Now I fully realize that one swallow does not make a summer, so in consequence make no claims for this method of treatment other than it deserves additional trial at the hands of the profession in those cases where the admittedly correct treatment, prompt removal, is not permitted.

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*"DROPS."

H. L. WALKER M.D.,

HOT SPRINGS, ARK.

The "drops" that I refer to in the title of this paper are not the "morning drops" of the chronic gonorrhoeics nor the perfumed drops of Fowler's solution, so often used in malarial districts, but are the "drops" exclusively referred to in Hot Springs where "drops" mean "potash" and "potash" means iodide of potassium, sodium or any other iodid. There, even the small boy on the street knows that the doctor's most frequent instruction is to "keep on rubbing and increase your drops".

In choosing a subject as old as this one I can lay no claim to anything original, but I do wish to emphasize a few points in the use of the iodides in the treatment of syphilis which I think are often overlooked.

The first thing is, when is the drug indicated? Second, when should it be left off? Third, how should it be given?

I believe that whenever there is a syphilitic manifestation present, be it secondary or tertiary, the patient should be put on the iodides as well as mercury. Given two cases of syphilis under as nearly similar conditions as possible and with lesions of the same type; put one case on mercury alone and in the course of time the lesions will disappear. Put the other patient on both iodide and mercury—push the iodides—and the lesions of this latter patient will get well in one-half the time it took the first one, or less. And that is what the patient wants. But don't think that I mean the iodides can cure syphilis, for such is not the case. This has been amply proven by clinical experience and in recent years by observations of the results of the Wasserman test.

Second, when should the drug be left off? Whenever there

*Read before the Clarksdale and Six Counties Medical Society.

is no syphilitic manifestation the iodides should be discontinued. The mrecury should of course be continued, except at the regular stated intervals of rest. These intervals should never be longer than three weeks during the three years of treatment. It is quite a common practice to give small doses of iodid during these intervals to help eliminate the mercury given previously, but the mercury will take care of itself and needs nothing to help its elimination.

Third, how should the iodides be given? This is where the title of the paper comes in. Give it by the "drop method", never use the old "mixed treatment" idea of putting both drugs in one prescription—it is a bad way to administer either drug. Mercury given internally is the worst way to use it for several reasons. First, this has been proven by the fact that mercury given by inunctions or intramuscular injections will soon render a positive Wasserman reaction negative while mercury by the mouth for the same length of time will only partially, if at all, change a positive Wasserman reaction. Second, you are much more apt to have the toxic effects before the desired results are obtained when it is given by the mouth than when given otherwise. Third, if you give mercury in the same prescription with the iodides you necessarily have to use a soluble salt—and then to have any anti-luetic effect you will have to use such a large dose that you will not be able to continue it for any length of time. But even though you do not agree with me in general about the internal administration of mercury and, letting the convenience of the patient influence you, insist on giving it by mouth, then use one of the insoluble preparations, preferably mercury and chalk. For this is the metallic form of the drug and owing to its slow absorption it gets into the lymphatic system where it does the real good while the soluble salts even in small doses are rapidly absorbed and enter into the circulation of the blood and are eliminated too quickly.

Equally bad is this method of giving the iodide. Give the saturated solution and by the "drop method" because first the dose of the iodides can never remain stationary for any length of time with the best results to the patient. Second, because you can work your patient up to a much larger dose and with much less constitutional disturbance. What I mean by the "drop method" is to start the dose at about ten drops *t. i. d.*, increasing the dose gradually, say one drop each time, until the patient shows some symptoms of iodism, then reduce the dose to about two-thirds the maximum reached and again start the increase. Repeat this each time any marked iodism is shown and the maximum dose reached will get much larger and larger.

These large doses are often necessary before the effect on the lesion is shown. That this is a fact often overlooked is shown by the following case of a syphilitic ulcer on the upper lip. This patient had been on persistent specific treatment for several months but the iodides had never been pushed beyond sixty drops *t. i. d.* The lesion steadily increased in size so his doctor decided it was cancerous and told him to seek a surgeon. The man insisted he had syphilis and so came to Hot Springs. There he went under the care of Dr. E. H. Martin, with whom I am associated. He was immediately put on intramuscular injections of mercury and the saturated solution of potassium iodide, increasing the dose as rapidly as possible. At the end of ten days when he had taken eighty minims or one hundred and sixty drops, *t. i. d.,* the lesion stopped its progress at least. Ten days later he was taking one hundred and eighty minims or three hundred and sixty drops *t. i. d.* or nine drachms daily without any iodism and the lesion was fading rapidly. Two weeks later he had only a dimple in his lip as a remembrance.

Some of you will doubtless argue that is was mercury and not the iodides that did the work in this case. I will grant that the lesion might have healed under the mercury, but where it took ten days to stop the progress of the lesion under the influence of both it would have taken three weeks at least to accomplish the same result with mercury alone and in the meantime his lip would have been practically destroyed. I will also add that the patient had had intramuscular injections of mercury before coming to Hot Springs.

The above case also illustrates another point and that is that in the great majority of cases those who need the iodides can undoubtedly take enormous doses.

Moreover we are prone to make two mistakes. First, the too frequent one of giving iodides alone in the routine treatment of syphilis. In every case of syphilis in which the iodides are indicated mercury is also needed, while the reverse is not true.

It happens far too frequently that potassium iodide alone is given to either a syphilitic suspect for diagnostic reasons or even to one in whom the diognosis is certain. In the first case if the suspicion of syphilis be correct the lesion will in all probability disappear and so will the patient. The importance of a long course of mercury is not being impressed sufficiently on the patient. Perhaps he on his own account takes more or less potassium iodide at times and so keeps a thin veil over the true condition. The spirochete under this mask goes on with its deadly work until finally it breaks through with an irreparable damage which no amount of treatment can correct.

In the second case when there is no doubt of the diagnosis it is a fact that the iodides alone are often prescribed. In the past two years I have taken the histories of two hundred and fifty cases of tertiary syphilis, including a good number of parasyphilis, and of those two hundred and fifty cases at least twenty-five per cent. had taken a considerable amount of iodides in the routine treatment of the disease, without mercury and without symptoms present.

Secondly, that of not giving large enough doses of the iodides in the face of severe lesions, thus allowing an unnecessary destruction of tissues and suffering to the patient.

The first case also illustrates this point but to show that this is a point frequently overlooked the following case is given:

Negro woman, aged twenty-three, quite emaciated and cachectic, weight ninety-four, weight when in health one hundred and twenty-two. Initial lesion followed by secondaries three years previous, more or less sore throat ever since this, has gotten decidedly worse. Six months before when she came under treatment the back portion of the soft palate and uvula were entirely gone, there were several small ulcers on the tonsils and a large one on the posterior wall of the pharynx. She had been unable to swallow anything solid for several weeks. Patient had taken much "blood medicine" from a physician which doubtless was a "mixed treatment". She was put on the intramuscular injections and increasing doses of iodides. Within five days the throat was improving and the dose of the iodides was thirty drops *t. i. d.* Within three weeks the dose of the iodides was one hundred and twenty drops *t. i. d.* and the lesions were healing fast. The dose of the iodides was now held stationary and at the end of another week all lesions were healed and the patient weighed twenty pounds more than when she began treatment a month before.

As I have said above, this patient had doubtless been taking both iodides and mercury at home as she recognized the taste of the potassium iodide, but the dose had not been properly regulated. Now if that doctor had given the "drops" instead of teaspoonful doses of a weak solution she would automatically have reached a dose which would have accomplished results and she would not have had a hole in the roof of her mouth to be recognized as far as you could hear her voice.

So let us not hereafter give our patients prescriptions containing ten or twenty grains of the iodides to the dose, with the result that the patient does not get a sufficiently large amount or else gets so much in the first two or three doses that

severe iodism is produced, the medicine thrown away and you never see your patient again.

Give it by drops, gradually increasing the dose until a slight iodism is produced or else a result is accomplished. Make the patient report often to you and watch him closely. Even if this can't be done, give explicit directions and the maximum useful dose will be automatically reached without any marked iodism and the patient will receive the proper benefit.

Doubtless some of you will think that I am writing of instruments soon to be discarded and made useless by the much talked of "606". However, it does not seem to me to be reasonable to feel certain of the absolute cure of syphilis by "606" until ten or fifteen years at least have passed and it has been proven that the spirochete has been completely eradicated from the system. During this interim we will have ample need of both mercury and "drops".

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*ACUTE ENTERITIS.

W. H. FRIZELL Jr. M.D.

BROOKHAVEN.

Strictly speaking, acute enteritis is an acute inflammation of the upper intestine, but for practical purposes this definition is not broad enough, as any inflammatory condition of much significance of the upper bowel soon spreads to the colon. Therefore in this brief paper will be included some conditions involving both the small and large intestines.

Of the various types the most common is catarrhal, which may involve a greater or less portion of the bowel, and for sake of further division may be termed duodenitis, ileitis, etc.

The disease is very common, occurring in persons of all ages, but most common in infants and old age. It may be primary or may be secondary in the course of some other disease. Some people are more susceptible to it than others.

The most frequent causes of primary enteritis are errors in diet, the ingestion of unripe or over-ripe fruits, fresh raw vegetables, impure milk or drinking water, tainted meats, change of climate or of drinking water. Sudden chilling of the body in the aged is very frequently a cause, as is excessive heat. These latter two are in the very aged and very young very potent causative agents, but should be classed as predisposing.

*Read before the Tri-County (Pike, Lincoln, Copiah) Medical Society.

Toxic substances have their share also in the etiology. The prolonged use or the excessive use of certain medicines will produce in some persons a violent diarrhoea.

Under the head of secondary causes may be mentioned rapid passage of food out of the stomach into the intestine; various acute infections, as typhoid fever, dysentery, malaria, tuberculosis, and toxic substances. Noticable under this head comes the diarrhoea of chronic nephritis, cancer, anemia and other constitutional diseases. Extensive burns are sometimes followed by duodenitis and consequent diarrhoea.

Pathologically the disease can not be studied very closely, but in life as has been seen on abdominal section the mucus membrane presents a red, swollen condition and there is increased secretion of mucus. The solitary and the agminated follicles are enlarged and sometimes show signs of ulceration.

Diarrhoea is usually present though not always a symptom —yet it may be the only symptom. There is in most cases more or less pain, occasionally so great as to be alarming, due to increased peristalsis and cramping of the bowel.

Fever may or may not be present. In the initial stage it is nearly always absent. Nausea is one of the most persistent symptoms in some neurotic patients and at times is hard to control.

The stools are frequent and watery. This liquid condition is due to the increased intestinal secretion and to the contents being swept down into the lower bowel before absorption takes place.

Partial or complete loss of appetite is also noticable, while thirst is greater and if gratified increases both the nausea and the diarrhoea. If the enteritis is caused by the ingestion of any toxic substance there is sure to be marked depression, attended by profuse perspiration, cold, clammy hands, hollow eyes and general pinched look of the face and a subnormal temperature. If the attack is confined to the upper bowel alone the stools will be watery and contain particles of undigested food, in fact look as though just gulped down. Acute primary enteritis usually lasts but a few days, unless death relieves the scene, but secondary enteritis, especially that due to grave constitutional troubles, usually passes on and becomes chronic.

In dealing with inflammatory conditions like these it is of great importance to make a diagnosis of the region affected and character of the disease, or rather the cause. When the small bowel alone is affected there is less diarrhoea but more pain and of a colicky nature. During the first few hours the patient will be drawn up and say that his most annoying

trouble is his "stomach ache". In affections of the large bowel there is usually the reverse of the above; the stools are frequent but less watery, and have quantities of mucus. After this point is settled the treatment can be more intelligently directed.

The patient should be kept strictly in bed, for rest is imperative. Empty the bowel with castor oil or some other bland purgative, if not already empty of all offending and effete matter. For the nausea and pain, morphia given hypodematically is best borne. Cracked ice for thirst, given cautiously as too much will invariably aggravate existing conditions. Bismuth preparations are thought by some men to exert great influence in relieving this troublesome malady but in my own experience it has proven very disappointing. I have exhibited it in large and in small doses only to receive the same verdict. Outside of opium most medicines are mere placebos. In depressed conditions strychnine and spirits are very remedial.

Diet in this as well as many other diseases plays the chief role, and upon its wise employment depends most of our success in relieving most types of enteritis. The patient's food must of necessity be of a bland and easily assimilated character. Light broths, gruels, egg albumen and the various alimentary elixirs and stmulants may be given, but milk and animal broths are to be strictly interdicted. Solid foods are not to be given until the bowel has regained largely its former healthy state. The whole treatment resolves itself into flushing the alimentary tract, diet and rest in bed. So called "intestinal antiseptics" are as tinkling cymbals and sounding brass.

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*INTESTINAL OBSTRUCTION DUE TO INTUSSUSCEPTION AND VOLVULUS.

J. C. WALKER M.D.,

HOULKA.

The discussion of a subject like this is usually the work of a surgeon. I lay no claims to surgery, and offer no apology for being a country doctor. These cases do occur in the country, far away from any hospital or surgeon, when it is a question of hours until too late for an operation.

I believe that we are fully justified in doing a laparotomy at home. I grant the very high death-rate from such an operation, but I believe in most of these cases valuable time is lost

*Read before the East Mississippi Four County Medical Society.

by the expectant plan of treatment. We now have a death rate in the hands of the very best of surgeons of between fifty and seventy per cent. This makes this subject very interesting, as prompt and accurate diagnosis may mean life when delay means death.

I shall not attempt to outline the symptoms except to call attention to the facial expression which I cannot describe, but I am sure that any doctor who has ever seen it once will never forget it.

I believe that when we have a history of some intestinal disturbance, intermittent colicky pains, passage of blood and mucus and presence of a tumor, that we are safe in making a diagnosis of intussusception and that we should not waste much time with such treatment as enemas, air inflations, inverting child and gentle manipulation. This treatment is all right and I think should be tried in every case, but I am sure the death rate from this condition could be markedly reduced by an early operation. That these patients will die the following cases show:

Case I. Infant, well nourished. Had otitis media suppurata some time before, but no discharge from ear recently. Was put to sleep one afternoon in May in seemingly perfect health. Awoke about four o'clock and its mother noticed something was wrong. It would cry out as if suffering pain but was soon easy, had a diarrhoea a few days before, bowels moved well that morning. I was called about 8 P. M. and found the child tossing its head and crying. Pulse very rapid, temperature in rectum 99° F., abdomen slightly distended and tympanitic, pain intermittent as child would cry awhile and then go to sleep. I examined ears and found slight perforation in both drum membranes. I washed out ears with warm water and patient went to sleep for about an hour, awoke and vomited some bile-stained matter. I left small doses of calomel and saw patient next morning. The mother had given oil and there had resulted a small action which stained the napkin red. I thought this was due to strawberries fed to the child the day before. Pulse was still very rapid, temperature normal, abdomen distended, patient was resting nicely while I was there, but mother said he still had attacks of pain and vomiting. I directed dose of castor oil and hot turpentine stupes on abdomen and gave lactated pepsin and bismuth subnitrate. Saw the patient at 7 P. M. on the same day with Dr. W. C. Walker. Pulse was very rapid, temperature normal, abdomen distended, considerable shock, peristalsis marked, relaxed sphincter, was passing blood and mucus. I tried high enema and could not

introduce tube. Finger in rectum showed tumor which could be palpated through abdominal wall. Diagnosis intussusception. Tried reduction with finger. Morphine was given hypodermatically, nothing by mouth. Operation advised. We repeated high enemas several times. Vomiting was persistent all night, was stercoraceous at nine next morning. Left at 10 A. M. for Memphis. Patient's condition rapidly grew worse and died before reaching Memphis.

Case II. Boy, one of twins. Had some gall-bladder trouble all his life. Repeated attacks of jaundice for several months previous. Would have attacks of colic about once a week. I put him on Pill Cholelith and he seemed to improrve rapidly. Had no attacks of colic for several weeks. Saw patient July 19th. Pulse rapid, temperature normal, had diarrhoea several days previous, bowels moved the day before, abdomen was distended, was complaining of pain in belly which was intermittent, no vomiting. I gave enema and he passed considerable fecal matter. Gave six half-grain doses of calomel and directed oil. Next morning bowels had not moved and he was vomiting bile. Gave high enema of olive oil. He passed some fecal matter.

I directed enemas repeated every four hours. Strychnine sulphate one one-twentieth grain and atropine sulphate one three-hundredth grain every four hours. Patient's condition was good, no shock, he wanted to eat. Next morning bowels had not moved, vomiting bile, was very restless, pulse rapid, pain more marked. Passed some mucus.

Nothing was given by mouth except chipped ice. High enemas repeated. Operation advised.

With Drs. Priest, Mitchell and Walker a long median incision was made and after careful search an intussusception was found in lower portion of small intestine, which was easily reduced. Gall-bladder was markedly distended and I think should have been opened and drained, but as patient was not taking anesthetic kindly abdominal opening was rapidly closed and patient put to bed. He was very restless after operation and died about five o'clock next morning.

Case III. Boy, age ten years. Previous health good, well nourished. Ate heartily at supper. Had some diarrhoea during night and some vomiting. About six o'clock went out of doors, was gone a short time when his father found him in the yard in an unconscious condition.

Dr Mitchell and I hurriedly called and found boy still unconscious, severe shock, pulse very rapid, abdomen slightly tympanitic and violent peristalsis. We gave high enemas and

patient passed some fecal matter. Gave few inhalations of chloroform and tumor could be outlined near umbilicus on right side. Patient was rapidly growing worse. Tympanites increasing. Diagnosis intestinal obstruction. Operation advised and at ten o'clock, with Drs. R. P. Donaldson, J. B. Mitchell and W. C. Walker, a long median incision was made and we found a volvulus in central portion of small intestine which was relieved. Intestines were wrapped in hot towels until color was about normal, abdominal opening closed and patient put to bed. Shock not near so marked as when he went on table. Was given hypodermatically, one-forth grain morphine which was repeated at intervals of from four to six hours. He had no fever following operation and was able to sit up on the tenth day. Health perfect since.

Case IV. Report by Dr. J. B. Mitchell. A girl baby, aged four or five months, white. Dr. Mitchell saw patient first in morning. Temperature 99° F., very restless, kidneys acting well, bowels constipated, minute doses of calomel followed by oil. Saw patient again in the evening, gave low enema. Saw patient next morning with Dr. W. C. Walker. Patient gradually growing worse, passing blood and mucus, relaxed sphincter, tumor easily felt. Diagnosis: intussusception. Tried to reduce with finger in rectum, high enemas given. Operation advised. People lived in country and before preparations could be made to go to Memphis patient was dead.

Case V. Infant girl, aged five weeks. Parents Dr. J. B. Mitchell and wife. Baby was well and hearty, bowels acting four or five times daily until December 25th. 1910. Bowels became constipated, baby being a little fretful on December 27th. Tongue had a white coat. Given three doses of one-fifth grain calomel followed by oil. Got no action. Before retiring baby was more fretful. After being put to bed with mother and given breast, went to sleep, slept well until three or four o'clock, but was soon quiet and slept until five o'clock. Was very sick by this time. Glycerine suppository introduced in rectum, fairly good action from bowels, violent peristalsis. Dr. W. C. Walker was called at 7 A. M. High enema given, passed some fecal matter and mucus, vomiting bile, having convulsions at nine o'clock, rapidly grew worse and died between eight and nine o'clock in evening of same day on train on way to Memphis for operation.

I report the above cases to show the folly of waiting too long and I am sure that if it were not for the persistent vomiting many a child with an intussusception or volvulus would be killed with drastic purgatives.

I believe that an early operation is indicated in every case and that our cases will be few that we will have time to get to some distant hospital and surgeon and that we must operate at home, because the vomiting and pain is so severe that every moment we wait our patient is rapidly losing strength.

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*THE MEDICAL TREATMENT OF APPENDICITIS.

J. W. JORDAN M.D.,

LEXINGTON.

This subject has been discussed *pro* and *con* and thoroughly ventilated during the past decade or two, until there is but little left to add; hence this paper is written more with a view of bringing about a discussion of the subject than of launching any new idea. The knowledge of this malady is probably as old as the history of medicine, but of recent years a more correct understanding of it has to an extent changed its nomenclature and revolutionized the treatment. In an old English work on the practice of medicine by Eberle written about the beginning of the 18th. century it is thoroughly described under the head of typhilitis and peri typhilitis, believing the inflammation to be confined to the coecum. The treatment consisted of purgation, hot poultices and bloodletting, chiefly, and the mortality even at that early date does not appear to have been great. Like most diseases, especially those of a local character, the name at once indicates the organ affected, viz.: the vermiform appendix. That this disease has been thoroughly discussed with many able defenders between the modern surgeon and general practitioner, and yet left an unsettled question in the minds of many prominent men as to whether or not surgical interference is always demanded is *prima facie* evidence that the vast majority of cases will recover under either treatment. That an early operation properly performed usually immediately terminates the disease is admitted by all. That the mortality is lighter than almost any other malady with medical treatment is the verdict of many country practitioners. There are but few diseases wherein the diagnosis is more easily made than appendicitis. Even at the inception of the trouble you often find your patient vomiting, elevation of temperature, with or without rigors, right leg flexed upon abdomen, intense pain, tender on pres-

* Read before the Holmes County Medical Society.

sure at the point midway between the umbilicus and crest of the ileum on the right side and you can safely pronounce it appendicitis. We find several types, or perhaps it is better to say stages, or conditions in appendicitis, and it is very important that they be early recognized. The simple swelling of the tube with proximal end often draining pus into the intestine, constitutes the recurrent, or catarrhal, form. The accumulation of pus in the tube with a high inflammatory condition extending to the adjacent tissues, resulting in adhesions from the throwing out of the products of inflammation, and finally emptying into the intestine could be designated as another type. By far the most formidable condition is where we find the appendix converted into a pus sack, largely distended, with thick walls, there to remain until let out by an incision, or bursting into the peritoneal cavity to find its way into the scrotum, or pass under the posterior peritoneum to a point in the lumbar region; or down in front under Poupart's ligament, there to be let out by the knife. This process usually results in a complete destruction of the appendix and permanent relief to the patient. I have seen within the past twelve months seven cases of appendicitis, among which were found the various described conditions, yet the treatment has been decidedly routine, and as near surgical in nature as could be without the primary operation, good drainage by nature's route, and antiphlogistics. I have but little patience with the theory that pus is ever absorbed. I have never used ice to any extent because I found most patients intolerant to its use, and they recovered so nicely without it. It is good practice to thoroughly empty the patient. We usually find that nature has accomplished this for the stomach. It matters not how open the bowels may be I use a low enema first; after its return I slowly introduce a long colon tube, and as thoroughly as possible irrigate the upper bowel with turpentine, glycerine and hot water not allowing the fluid to remain—after which I disconnect the tube and repeat the procedure until satisfied that the digestive tract is as empty as possible. Let tube remain in rectum and slowly inject a mixture of echafalta and turpentine in four to six ounces of glycerine. This should be retained and repeated, as it rapidly depletes the engorged mucous membrane. Tablespoonful doses of saturated solution magnesium sulphate administered in aqua cinnamon by the mouth every two or three hours, assists the hygroscopic properties of the glycerine and keeps an excellent system of drainage. For nausea I find small doses of morphia sulphate, with bismuth subnitrate, given with carbolic acid in water to be

very useful. Patients usually do better as the acute attack begins to subside with small, often repeated doses of calomel. Pain is a most distressing symptom in every case I have seen and can only be relieved by large doses of morphine given hypodermatically. I have several times been compelled to administer chloroform for its relief. Antipyretics are nearly always indicated. I generally administer them well guarded and do not push them to the extent of free diaphoresis. Hot poultices, so much condemned by some, are very comforting to the papatient for this fact and because my patients have done well under their use I apply them freely. I prefer flaxseed meal, well saturated with olive oil, and covered with oiled silk, which I think materially assists their action. They are soothing to the patient, and mine have recovered in spite of their use. As to diet, I think it much better if they take nothing for four or five days. Then it should be simple, requiring but little effort from the digestive organs. There is a large per cent. of the catarrhal form of appendicitis that will have recurring attacks, usually two or three, sometimes more. They seem to continue until the products of inflammation have destroyed the lumen of the appendix and it has been converted into an impervious cord. As to what becomes of the numerous adhesions which occur during these acute attacks I can only surmise. It is not uncommon to see a patient so badly drawn that to walk or stand erect is quite impossible for some weeks, yet after a time the patient gradually assumes the normal condition. I am of the opinion that appendicitis is much more common than one would suppose, as it is now quite the custom of surgeons in doing abdominal operations to remove the appendix. They say that in many instances where no previous trouble was expected the appendix exhibits every evidence of a former inflammation. I have seen probably forty-five or fifty cases of appendicitis during the past fifteen years—some by courtesy of other physicians. These have all recovered except two. One succumbed to the surgical operation, the other to the gangrenous form, a condition fatal from its very inception, not amenable to any treatment.

This malady, though essentially of a surgical nature, is not near so fatal as was once thought to be, and I doubt exceedingly whether many surgeons can claim a larger per cent. of recoveries than the general practitioner. It was once thought to be caused by the invasion of a foreign substance into the appendix, but no doubt habitual constipation and a disordered condition of the digestive tract can claim more victims than all other causes.

Removals.

The following removals from the state are noted in the reports from various county secretaries to the state secretary:

P. L. Bellenger, Natchez to L'Argent, La.
F. L. Bott, Lexington to Memphis, Tenn.
E. M. Causey, Gloster to Baton Rouge, La.
R. A. Creekmore, Pittsboro to Ashville, N. C.
S. T. Hamberlin, Richey to Tampa, Fla.
H. McMullan, Mize to ————————, New Mexico.
J. A. McDonald, Durant to Memphis, Tenn.
M. T. Rogers, Egypt to Texas.
M. O. Shivers, Greenville to Colorado Springs, Colo.
W. R. Strange, Gulfport to New Orleans, La.
F. L. Walton, Meridian to Muskogee, Okla.
Jos. Whitaker, Natchez to Ashwood, La.
M. F. Wilson, Sardis to New Orleans, La.
C. R. Wright, Mt. Pleasant to ————————, Tenn.

Mississippi State Medical Association.

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From the interest manifested in medical legislation by the members of the Association and from reports received from various sections of the state, there is no doubt that most of the gentlemen who will meet at the capitol in January to enact laws for our government are fully informed in a general way on those matters that will be brought before them by our committee. Indeed a number of the legislators have already expressed themselves as favoring a better practice act and a bill providing for the registration of births and deaths. As to increasing the appropriations for the Board of Health, many legislators are "from Missouri" and while they can undoubtedly be shown it will be necessary to demonstrate that the Board has other functions than to examine applicants for license and take charge of epidemics. And in showing that such is the case let us go about it in the right spirit, not taking it for granted that the legislators either know or should know these things. The Board has not yet been able to carry its educational campaign through the entire state. Only recently, since the primary, the writer talked with a legislator who didn't know anything about it, and he is a fairly intelligent and fairly representative citizen. He said frankly that with regard to voting for an increased appropriation he would have to be shown the necessity for it, and at the close of the conversation admitted the necessity and asked for further detailed information that was not then available. From this it appears advisable that every physician in the state post himself, in a general way, on what the Board has done and is doing—the actual facts—and what will be the cost of what it proposes to do—the actual figures, in dollars and cents—so as to be able to give some other answer than "I don't know" when a legislator quizzes him. They expect us to know and if we don't show that much interest the Board may be left in a hole again.

Society Proceedings.

East Mississippi Four County Medical Society met in Aberdeen June 20th. The visiting members were met at the train by the local physicians and repaired to the Pickle Hotel for dinner. Afterwards the meeting was called to order in the Elks Home. In the absence of the president Dr. C. B. McCown, vice-president for Monroe County, occupied the chair. The secretary being also absent Dr. W. J. Coleman was chosen secretary *pro tem.* Drs. Coleman and Boyd presented a case of laryngeal paresis following stab wounds of the head and neck. Dr. McCown read a paper on la grippe which was discussed by Drs. Bryan, Boyd and Walker. Dr. Bryan reported a case of gonorrhoeal ophthalmia in an infant. A similar condition was related by Dr. Coleman, occurring in a man forty years old; the case being first diagnosed and treated as traumatic conjunctivitis. On motion of Dr. Boyd, seconded by Dr. Green, it was resolved that the members interview the several candidates for the legislature and ascertain if they agree to our proposed medical legislation. On motion of Dr. Bryan, seconded by Dr. Spencer, the society passed a resolution expressing our sympathy to Dr. C. T. Keyes in his failing health and our wish for a speedy improvement. Those present and participating in the meeting were Drs. Acker, Boyd, Spencer, Sims, Dilworth, Bryan, Walker, Green, Farrar, Coleman and Boggan.

F. J. Underwood.

Harrison County Medical Society met at the Great Southern Hotel, Gulfport, Aug. 8th. at 2 P. M., President G. F. Carroll of Biloxi in the chair and the following members in attendance: Drs. Segura, Welch, Parker, Hood, Hopper, Fahnestock and West. An interesting paper was read by Dr. Parker on "Varicose Veins With Special Reference To Schede's Operation". The subject of puerperal eclampsia was then taken up and cases of interest reported by Drs. Parker, Fahnestock, Hood and others. Three of the cases reported included a swelling of the tongue to such an extent that it protruded from the mouth. Several of the cases were in individuals suffering from hookworm anemia. Dr. Segura reported a case of labor with severe pain but with no uterine contractions. The society voted thanks to the Great Southern Hotel for furnishing a meeting-place. Adjourned to meet at Gulfport Sept. 12th.

B. Z. Welch.

Washington County Medical Society met in the City Hall, Greenville, July 5th., Dr. W. L. Howard in the chair. The following program was carried out: Roll Call; Reading of Minutes; Clinics; "Illusions And Idiosyncrasies In The Treatment Of Malaria", H. L. Sutherland, Rosedale; "Pellagra", E. G. Martin, Benoit; "Some Recent Observations And Literature On Pus Conditions In The Abdomen", A. G. Payne, Greenville. The meeting closed with a smoker which was much enjoyed. Those present were Drs. H. L. Sutherland of Rosedale; C. M. Clinton of Gunnison; J. E. Williams and E. G. Martin of Benoit; J. F. Simmons of Percy; W. S. Wasson of Moorhead; E. A. Cheek of Arcola; J. D. Smythe, E. C. Smythe, O. W. Stone, S. Stein, A. G. Payne, A. J Ware, J. J. Ferguson, J. M. Halbert, W. L. Howard, H. A. Gamble, R. C. Finlay and B. T. Orendorf of Greenville. Visitors were Drs. T. M. Dye of Clarksdale and H. L. Cocherham of Gunnison. This was one of the best meetings in the history of the society. All papers were good and well discussed by all present. Several clinical cases were reported which were of especial interest.

B. T. Orendorf.

Book Reviews.

DIAGNOSTIC METHODS. Second Edition Revised. A Treatise on Diagnostic Methods of Examination. By Prof. Hermann Sahli, Director of the Medical Clinic, University of Bern. Edited with additions, by Nathaniel Bowditch Potter, M.D., Assistant Professor of Clinical Medicine, College of Physicians and Surgeons, New York. Octavo of 1229 pages, containing 472 illustrations. W. B. Saunders Company, Philadelphia and London. 1911. Cloth, $6.50 net; Half Morocco, $8.00 net.

The first edition of this invaluable work appeared in 1905, and has since been considered by practitioners and students of medicine as the greatest work in its line ever produced. The present edition, which is the second American, is an authorized translation from the enlarged and revised 5th. German, is more than well known in this country; it is popular, if one can use this term in reference to so scientific a work. The book is written on a logical plan, beginning with the history or note taking, general condition of patient, and taking up seriatem, the examination of the different functions and organs of the body. Then follows a very complete discussion of the various laboratory methods affecting the examination of each organ under discussion, the examination of the urine,

feces, sputum and blood being more complete than in many text books devoted to laboratory diagnosis alone. The best feature of all is that this work is no mere compilation, but the outgrowth of the distinguished author's own experience, and, as such, every method is time-tried and fully tested. The American editor, Professor Potter, has treated the text in the manner such a monumental work would deserve, while Messrs. W. B. Saunders have given it the proper typographical setting which adds so much to the reader's pleasure. We would advise every up-to-date physician to own and place Sahli at his right hand, and no better consultant will be found in time of need.

MYERS.

A TEXT BOOK OF MEDICAL DIAGNOSIS. By Jas. M. Anders M.D., Ph.D., Ll.D., Professor of Theory and Practice of Medicine and Clinical Medicine, Medico-Chirurgical College of Philadelphia, etc. and L. N. Boston A.M., M.D., adjunct Professor of Medicine, Medico-Chirurgical College, etc. W. B. Saunders Co., Philadelphia.

Like many of the widely heralded works on diagnosis this volume is a distinct disappointment. While of undoubted reputation as a teacher, Dr. Anders is hardly up to the same standard as an author and the heaviness and absence of lucidity that is so characteristic of his "Practice" is even more manifest in this his latest effort. We note, too, several details that vary considerably from what is generally taught, such as the mention of the Argyll-Robertson pupil on page 1053. A valuable and unique feature is the introduction of "moving picture" views of locomotor ataxia, multiple sclerosis, paralysis agitans and the like, but picture work was ever a special feature of Saunders' book.

HOWARD.

A MANUAL OF THE DISEASES OF INFANTS AND CHILDREN. By Jno. Ruhrah M.D., Professor of Diseases of Children in The College Of Physicians And Surgeons, Baltimore, W. B. Saunders Co., Philadelphia.

That this little handbook has found favor in the eyes of students is amply testified by the fact that again an edition is required, two editions and a second printing of the first having been exhausted since 1905. It is a capital book for quick reference and while it does not fill the place of a text-book—it is not supposed to—it is admittedly suited for the purpose for which it was intended, that of a students' manual.

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*CAUSE AND TREATMENT OF UTERINE HEMORRHAGE.

S. A. EGGLESTON M.D.,

LEXINGTON.

Before getting into the main part of my paper I want to make to this society an honest confession. It has occurred to me that there comes a time in the life and work of every man that no matter how skilled or learned he may be in his trade or profession, there are certain parts of that work in which he feels himself more or less deficient. The practice of medicine, especially as it is practiced by most, if not all the members of this society, embraces so much that I think the general practitioner deserves every credit for being as proficient as he is. Each has to be a specialist in every branch. In the treatment of diseases of women, I must admit that I have felt more at a loss as to how to proceed than with any other class of patients which it has been my fortune to have the care of. By this I mean making an accurate, scientific diagnosis and applying the proper treatment. I know how to make some sort of an examination and find, generally, some sort of trouble, and then to use some sort of treatment, but that isn't practicing medicine as I like to do it, and, as I said, I frequently manage such cases with very little satisfaction to myself, and I imagine with as little satisfaction to my patient. To me it has proven a very difficult hill to climb, and I gladly contribute my share to to-day's entertainment, if my paper will elicit a discussion which will be a help, not only in the management of uterine hemorrhage, but in other gynecological cases.

The subject assigned to me by the programme committee is The Cause And Treatment Of Uterine Hemorrhage, or more particularly menorrhagia and metrorrhagia. This embraces so much that I have necessarily had to be brief in my discussion of it. The best guide I have found, I think, to follow is that in Kelly's Medical Gynecology, where the causes are divided into local, constitutional and vascular, when a patient suffers with excessive bleeding at or between the menstrual periods, I try

*Read before the Holmes County Medical Society, January 11th. 1911.

to satisfy myself as to whether or not she is or has been pregnant, and if I am dealing with a threatened or incomplete abortion. If the former, the usual remedies are indicated, such as rest in bed, quiet and some preparation of opium with a uterine sedative. Should it continue and abortion become inevitable, then packing the vagina and small doses of ergot (being guided by the amount of dilatation of the cervix) will usually have the desired effect. If the latter, a thorough curettage of the uterus.

Knowing that pregnancy or abortion does not exist, I would determine if there were any heart lesion, especially mitral regurgitation, or liver disease, such as cirrhosis, marked anaemia, rheumatic diathesis, scurvy, phthisis, or any infectious disease, all of which may produce flooding and call for appropriate treatment as when found under other conditions. Finding no cause for the homorrhage so far, and my patient being a young girl, in whom menstruation was being established, or an unmarried lady, I would not suggest an examination but would advise rest in bed for several days during the menstrual periods, keeping the bowels well regulated, hot sitz baths and a tonic of arsenic, quinine and strychnine. This not bringing relief, and in other patients, I would attempt an examination and begin feeling sorry for myself and patient, because this is where my deficiency really begins. Still, I would endeavor to find out the cause and would look first for trouble in the vagina for some abnormality, such as injury, a polyp or other tumor, which generally should be removed and the injury repaired to effect a cure. At the same time examine the cervix where we might find a cancerous condition, and if so the patient's general appearance would be an aid to the diagnosis, and the treatment would be as in cancer of the uterus, surgical. Of course in a case that could not go to the specialist palliative measures would have to be used, but there should be no hesitancy in what to advise. Determining that the hemorrhage came from further up, I would direct my attention to the uterus, tubes and ovaries. In the uterus there might be a tumor, a polyp or a cancer; or a backward displacement, an inversion or a subinvolution, all requiring proper treatment; or rarely we might find an endometritis as a cause of the trouble. When found, the uterus should be curetted and packed with gauze and other appropriate treatment carried out.

In examining further we might look for inflammation of the tubes or ovaries; extra-uterine pregnancy; cystitic ovaries; pelvic hematocele and other things and they should be treated accordingly. Thorough curettage will relieve it. The cause of the bleeding would nearly, if not always, be due to one or more

of the reasons mentioned and the successful treatment of this trouble depends upon finding and treating the cause more than in any other disease that I can call to mind. Still there are instances where we are unable to make a diagnosis, or do not see the patient even, but at the same time something must be done and there are certain remedies and means by which a great deal may be accomplished. Among medicines, we always think first of ergot, though its value as a general remedy is doubtful, and it is not prescribed now as frequently as formerly. Hydrastis canadensis, or golden seal, is useful in cases of subinvolution, interstitial fibroids and in cases where there is congestion of the uterus. It is better given between the menstrual periods, or beginning a week or ten days before the flow is expected. Viburnum prunifolium is useful when the menorrhagia is due to a constitutional cause or at the beginning or cessation of menstruation. Apiol, or ergo-apiol, given as the hydrastin, between the periods, I have found a good remedy. Stypticin I have never used, though it is highly recommended not only for the hemorrhage, but also to relieve the pain of menorrhagia in certain forms. It is better given hypodermatically. Styptol is said to be more efficient and cheaper than stypticin. Adrenalin, given three times a day, is good, as is calcium chloride. Gallic acid is used, I think, very generally, but I have not seen good results follow its use. Personally, I prefer sulphuric acid, diluted, or the aromatic. Of course there are other remedies, but these are the leading ones, and what has served me best is a combination of fluid extract of ergot and aromatic sulphuric acid in some suitable menstruum.

Locally, we may use douches, tampons, cold or hot applications, electricity, intra-uterine applications, or curettage. Hot douches can be used by almost anyone with a fountain syringe and ordinary common sense. The patient should lie on her back and the water should not be of a lower temperature than 110° F., otherwise it will do more harm than good. After using this two or three times a day, I often prescribe a solution of Monsel's solution in about a pint of hot water, to be used in a similar way. A vaginal tampon is often very useful, especially in cases where the period is excessive or unduly prolonged. They should be introduced with the patient in the knee-breast position and should remain in place from eighteen to forty-eight hours; on removing a douche to be used and another pack inserted if necessary. Uterine tampons may be employed, but I have never used one, and I do not think they are very generally recommended except in cases of abortion, or following curettment. Bouriaut of Geneva suggests an injection of

a two per cent. solution of glycerin into the uterus in place of the pack. Cold applications may be used over the lower abdomen. Electricity for this trouble I have never seen employed though it is recommended by some in some cases. Kelly strongly advises the use of nitric acid as a caustic to the interior of the uterine cavity, preferring it to other caustics, and uses it between the menstrual periods. He packs the vagina with gauze, uses a cylindrical speculum and passes the fuming acid on cotton up to the fundus. Great care is to be taken and the applicator immediately withdrawn.

As to surgical measures, I only want to mention curettage, and say that I think if it were more frequently employed at once without temporizing with various drugs and applications that the result would be more satisfactory in every way. Of course one has to be governed by circumstances, but where at all indicated it should be done, and done as soon as the arrangements can be made for it. Other surgical treatments come more under the care of the specialist, and I do not care to go into that.

In conclusion there are a great many proprietary and other remedies highly recommended for this and all uterine troubles, but I very much doubt their virtue in cases of hemorrhage except in so far as they contain more or less of one or another of the drugs mentioned above. Of course they may all be given in lieu of something better, but the real treatment of this condition is in finding and relieving the cause.

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*SURGERY OF THE APPENDIX VERMIFORMIS.

J. W. BARKSDALE M.D.,

WINONA.

The evolution of surgery of the appendix vermiformis has practically taken place within the past twenty-five years, or since the classical paper of Reginald Fitz of Boston, who put the role played by the appendix in its proper place and gave an impetus to the study of this organ and the diseases originating from it more than any other single investigator. The appendix had long before, however, been recognized by some surgeons as being capable, under certain conditions, of producing serious abdominal disturbance independently of an associated typhlitis.

Since I am asked to present a paper dealing only with the surgical aspect of appendicitis, I shall not attempt a description

* Read before the Holmes County Medical Society.

of the disease or go into any details other than those bearing directly on the subject. First, I wish to emphasize the fact that appendicitis is at all times a surgical affection and that there is no exception to the rule that at some time it should be operated on. There are, however, cases where operation has to be deferred from one cause or another and when medical relief must be attempted. This does not take it out of the category of surgical affections, for this delay or postponement of operative procedure may come from the physician, the family, the patient or the want of having close at hand a competent operator, or any other factor that may contraindicate any attempt at successful surgical interference. That there is a proper time to operate on any case, provided the essential factors for a successful outcome are at hand, cannot be denied, and the preferable time in all cases is within as few hours after the development of the initial symptoms as possible. Operation done at this period carries with it practically no mortality and offers the best assurance of absolute recovery that can be given the patient. At this time the operation can be done through the McBurney, or gridiron incision, without drainage. There are no adhesions and no pus to be dealt with, post-operative hernia or other complications are practically nil, and the patient makes an uneventful recovery in a very few days. There are three stages in which we are forced to operate on the appendix: first, in the period of election, mentioned just above. It is unwise to wait on any attack, hoping to do an interval operation, for it is not within the power of any man to determine what the outcome of a given attack will be. Of course, if we could determine beforehand that one would recover without serious complications arising we would be justified and should defer operative interference until the interval. There is perhaps no surgical affection at this time that is better understood and is more capably dealt with than appendicitis, yet with all the light that has been shed on the subject and with countless operations that have been performed in this field, we have never been able to account for some of its vagaries or to absolutely prognosticate what will be the issue. The stage of election terminates, in my judgment, within the first thirty-six hours, or at most forty-eight hours, and as we approach the border line of where it is advisable to operate and advisable not to do so, I know of no more perplexing problem to confront the surgeon. My experience along this line has not been such as to make me definite in my opinions, for in some cases where I have advocated and practiced delay, after the first forty-eight hours, hoping for the development of local abscess formation,

with its subsequent evacuation, I have had my only mortality with the exception of one case, operated on in thirty-six hours, and dying from a septic pylephlebitis, some three or four weeks afterwards. There was at the time of operation, however, even at this early stage, pus formation, and operation was not deferred in this instance, but was done as quickly as I was able to reach the patient. The second stage embraces that of pus formation and spreading infection, and in the light of the experience I have had, outlined above, I have come to the conclusion that it is best always to operate early in this stage and not to wait until extensive pus formation has developed or until the peritoneum is badly involved. Even early in the formation of pus, I think that the proper thing to do is to operate and limit the amount of damage done by prompt and thorough drainage. This damage is not confined to the actual involvement of the peritoneum, but is quickly manifest in a great many cases through its profound systemic disturbance, the brunt of which falls upon the heart. Of course this is usually the result of widespread peritoneal involvement, but there are cases which are at all times local, where there is a peri-appendiceal collection of pus with not more than a moderate amount of peritonitis, with a very rapid pulse and evidence of profound systemic intoxication that I believe offer the worst outlook of all cases save in long standing cases of general peritonitis, in which operative efforts have not been soon enough employed. I believe that a great factor in the production of a fatal outcome in this class of cases is the employment of chloroform as an anesthetic, for the toxaemia seems to act directly on the heart muscle itself and the added depression caused by the chloroform is more than it is capable of withstanding. It has been my practice recently to employ ether, regardless of all other conditions, in these abscess cases with marked cardiac depression. I would infinitely prefer risking possible damage to the kidney in a case in which albumin appeared in the urine, or a case with a co-existing bronchitis than to employ chloroform with its freedom from danger in these complications. Abscess cases should be drained thoroughly, this is the keynote of the situation. My preference for drainage material is rubber tubing, of sufficient caliber to insure the free outflow of the purulent material. Through and through drainage is indicated, or rather drainage from a stab wound situated at the most dependent part of the pus collection, in quite a number of cases. Irrigation of the pus cavity is unwise, as it may wash the pus through a small opening into the general cavity and general peritonitis result. My position,

then, is that all cases should be operated on as soon as it is possible, almost without reference to the number of hours that have intervened since the onset of the attack, save in a very small class in which operative outlook is practically without hope, and in others where a day or so has elapsed since the onset of symptoms and the patient is obviously convalescing or where there is a marked improvement in his condition. As Dr. Howard Kelly states, however, here comes in the duty of the surgeon, and even in these cases it may be well to acquaint the family with the almost hopeless character of the case and, if they and the patient are willing, to undertake operative relief, for there is a small per cent. that will be saved by intervention when the outlook is most desperate.

Cases with widespread peritonitis or peritonitis that is progressive and advancing call for the Fowler-Murphy plan of treatment, which consists of free drainage, semi-erect position of the patient and continuous proctoclysis. Some surgeons employ a continuous irrigating fluid through the abdominal cavity in addition to the above, while others content themselves with the method as indicated. It is astonishing to note the number of recoveries from the hitherto almost uniformly fatal affection under this simple plan of treatment, and it is equally astonishing that the method was so long in coming into vogue. The mechanical principle involved, it seems, would have suggested itself at the very outset of surgical efforts at relief in this condition, yet it remained for Fowler to bring this to the notice of the profession and John B. Murphy to work out the other details involved.

The third stage for surgical intervention is in the interval, and the safety of this measure is so well understood by the laity, as well as the profession, that operation at this time is becoming more and more common. I believe that this is in a way unfortunate, as it offers the main reason for deferring early operation in an acute attack, and many deaths are to be attributed to a failure to operate in the outset. However free from mortality the operation may be at this stage, it is not more so than in the very outset of an acute attack, and if the initial seizure has been at all severe we are almost sure to have complicating adhesions which will render more difficult the efforts at removal of the appendix.

As to the methods of operation, or technic of any given procedure, I take it that this society is too familiar with the details of this phase of the subject for it to require any discussion at my hands. Suffice it to say, however, that there is no simpler operation in a great many cases than removal of the appendix,

while, on the other hand, the surgeon may have to tax his ingenuity to the utmost to successfully remove the appendix in old adherent cases, or in cases that offer unusual operative difficulty by reason of malposition or other complications.

In conclusion, I wish to again call attention to the fact that the safest time always for surgical interference is within the first twenty-four hours, that the mortality after this time is progressively greater, rather dependent on the grave constitutional disturbance than on account of local conditions, and that ether must be the anesthetic of necessity rather than choice.

*ACUTE PARENCHYMATOUS NEPHRITIS.

JOHN O. GURNEY M.D.,

TUPELO.

Gentlemen and fellow-practitioners, I desire to direct your attention to the disturbance of the functions of the kidney, the scavenger of the body.

There is no nomenclature more comprehensive of this condition to me than that of acute parenchymatous nephritis.

There is no one organ of the body which is called upon by nature to eliminate from our bodies more noxious or poisonous materials than the kidney; for this reason I think it would be profitable for us to consider for a short time the conditions brought about by these sudden demands for elimination and ultimate pathologic changes.

Acute parenchymatous nephritis is an inflammation or disturbance of the functioning portion or cells of the kidney, the Malpighian tufts or uriniferous tubules.

This condition is the result of exposure to cold or wet, closing the pores of the skin and putting extra work on the kidneys; poisons that result from acute infectious diseases and fevers as: scarlatina, typhoid, yellow fever, malaria, rheumatism, diphtheria and sepsis; execretion of certain drugs and chemicals: turpentine, cantharides, phosphorus, carbolic acid, mercury and others of that class.

The appearance of the kidney is as follows: larger than normal, swollen, darker in color, drips blood on being cut, pelves much reddened; though at times the cortical portion is pale, and is easily removed, the organ being slightly enlarged.

Any poisonous substance that reaches the kidney through the circulation must necessarily enter the Malpighian tufts.

*Read before the East Mississippi Four County Medical Society.

The cells lining Bowman's capsule become irritated therefrom. First, cloudy swelling, granular, and fatty degeneration, exudation, consisting of red and white corpuscles and nonfunctioning cells, if the poison is severe. If the poison is not so virulent then a milder inflammation, with perhaps only cloudy swelling and partial loss of cell nucleus exists.

This brings about a disturbance in the functioning portion of the kidney, because there is a disturbance of circulation, hence excretory power.

The cells lining the tubules likewise undergo the changes characteristic of an inflammation, viz.: cloudy swelling, granular degeneration, fatty degeneration, loss of cell nucleus.

Casts of the tubules, consisting of blood corpuscles epithelium and exudate are present. Should the inflammation continue cell infiltration, even of interstitial tissue, would follow.

Acute parenchymatous nephritis as the result of cold or wet comes on very suddenly with headache, chilliness, nausea, vomiting, muscular twitching, often pain over the region of the kidney, tense pulse, dry skin, temperature at times 100-103° F., diminution of urine, sometimes even anuria; pallor, and swelling of different portions of the body, especially beneath the eyes and extremities. Resulting from acute infectious diseases, symptoms come on insidiously.

Many of us practitioners say with Shakespeare "Aye, there's the rub" when we confront the diagnosis. To have the proper conception of the existing conditions we should leave nothing undone which we are able to do for our patient.

Granting that we have elicited from the patient a history of typical acute parenchymatous nephritis we should at once resort to urinalysis, both chemical and microscopical, which reveals the true condition of things.

Urinalysis: quantity diminished even to the point of complete suppression, highly colored, with some sediment, specific gravity 1025 to 1030, smaller or larger quantity of albumin.

Microscopic findings: epithelial cells from tubules, red blood cells, casts of different kinds: hyaline, granular, epithelial and blood casts which alone reveal the true condition that exisits in the functioning part of the kidney and upon which we can rely.

Treatment resolves itself into two things: first, relieving the kidney of work, by calling into action the skin and bowels; and second, diluting the poison causing the disturbance, by giving solvents of proper kind. Both of these depend largely upon the cause producing the nephritic condition, as it is difficult in many cases.

As a means of increasing the function of the skin, warm baths or wet packs at a temperature of 100° F. are very efficient, afterwards covering patient with blankets and rubber sheeting, once or twice daily. Some resort to jaborandi or its active principle, pilocarpine, one-eighth to one-sixteenth grain.

But most observers claim the wet pack is preferable in children, and I should think same would be true of adults. Saline purge is the most satisfactory method of eliminating through the bowels. Compound jalap, elaterium and other drugs are recommended where there is much anasarca or effusion in serous sacks of the body.

On the subject of diuretics, there is a diversity of opinions. All warmly advocate the administration of water *ad libitum;* others advocate citrate of potash, strophanthus, or digitalis if the tension of pulse is lowered. Ferruginous preparations for anemia, as Basham's mixture, syrup of iodide of iron, syrup of phosphate of iron.

A very gradual return to semi-solid and solid food must be strictly adhered to.

The prognosis depends upon the causative agent, and the severity of attack. That produced by cold clears up ordinarily in three or four weeks, albumin diminishing, quantity of urine increasing, dropsy disappearing, and anemia gradually overcome.

Scarlatinal nephritis is more slowly overcome, also that of other infectious diseases or chemical irritants. In these the dropsical condition, along with the anemia, persists and uremia supervenes and death results.

There is a tendency for this acute condition to become chronic.

SEVERAL LISTS FOR OBSTETRICAL USE.

S. MYERS M.D.,

VICKSBURG.

The practitioner who does much obstetric work is often asked the question, particularly by primiparae, who, like the poor, we have always with us, "What shall I have ready for my confinement?" Unless one has a definite routine, some very essential detail is apt to be overlooked, and when most badly needed will be found absent. With this idea in mind, the folfollowing lists have been compiled from Hurst, Norris, Parvin, Lusk and Playfair, and have been found to cover every essential

that is needed in the average normal case. They have been divided into three parts.

1st. A list of articles to be carried in the obstetric bag.

2nd. A list of articles to be provided by the expectant mother.

3rd. A diet list.

Nothing original is claimed for these lists, but their routine use in printed form will add much to lifting the small worries of an obstetric case from the mind of the attendant.

1. List of articles to be carried in obstetric bag:

Soap—P. D. & Co.'s Germicidal Soap.

New hand scrub brush—5c kind.

Bottle bichloride tablets.

Braided Chinese silk for cord.

Pocket case, needles and sutures.

Needle holder.

Fluid extract ergot and 1 ampole ergotin for hypo. use.

Hypo. decime syringe.

Absorbent cotton.

Ten per cent. sol. cocaine.

Forceps.

Small faradic battery, while not absolutely necessary, is often invaluable in cases of suspended animation.

Chloral in solution 10 grs. to teaspoonful.

Half dozen five-grain quinine capsules.

One gown and one pair rubber gloves.

Half ounce bottle ten per cent. solution silver nitrate.

One tube catgut.

2. List of articles to be provided by expectant mother:

Towels.

Chloroform, 4 oz.

Brandy, 2 oz.

Vinegar, 4 oz.

1 bottle antiseptic tablets.

Cake P. D. germicidal soap.

1 roll narrow tape.

1 new fountain syringe.

1 bed pan.

Six to nine dozen sterilized sanitary napkins, same as sold for traveler's use.

1 lb. absorbent cotton.

1 talcum powder can filled with mixture of 1 part salicylic acid and 4 of starch for drying cord.

Castile soap.

8 oz. tinct. green soap.

3. Diet List.

First twenty-four hours—water and milk.

Second twenty-four hours—soup, one cup of tea, buttered toast.

Third and fourth days—milk toast, poached eggs, wine jelly, cornstarch, one cup coffee or tea per day.

Fifth and sixth days—soup, white meat of fowl, mashed potatoes in addition to above.

After seventh day, gradually and cautiously resume normal diet, avoiding too much meat.

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*PYORRHOEA ALVEOLARIS.

J. W. JORDAN Jr. D.D.S.,

LEXINGTON.

I was requested a few days ago to prepare for the consideration of the Holmes County Medical Society a paper on pyorrhoea alveolaris or, as it is commonly termed, Riggs' Disease. The failure of the medical profession at large to recognize this horrible disease and the serious consequences resulting to the body and mind therefrom, have caused me to try giving you a paper that will show you the importance of knowing the disease and its evil effect. A subject covering a broader field or one of more importance could not have been requested from a dentist. This is a vast subject and has been more written about and had more research work done for it than any other disease, almost, that we know, and taking this in consideration and only having a few days in which to do this thinking, I tried to be as much to the point and as concise as possible, and will attempt to confine myself to the clinical case as it occurs in my daily practice, without consuming much of your time with a theoretical paper.

Pyorrhoea alveolaris is not a recent disease or one due to modern constitutional states alone, as is rendered evident from examination of the skulls of ancient as well as modern races, and in the alveolar processes of many skulls are found processes resembling closely those which were known to have been the result of pyorrhoea during life. Recorded observations of this disorder date back to the early part of the eighteenth century.

Pyorrheoa alveolaris, strictly defined, means a flowing of pus from an alveolus. It describes merely a symptom which may be and usually is attendant upon a variety of disorders.

*Read before the Holmes County Medical Society.

The term is applied in clinical dentistry to a complexus of pathological conditions, which more or less clearly indicate a specific disease. The term includes all of those cases of morbid action, characterized by the following features, only a few of which are the most commonly met with: necroses of retentive structure of the teeth, atrophy of alveolar walls, with chronic hyperaemia of gum tissue, which leads to limited hypertrophy; after a variable time the teeth loosen and drop out, and morbid action ceases with their loss.

There is the greatest diversity of opinion as to the cause of the disease. Some think it due to constitutional and hereditary causes, low vitality and feeble vascularity; some think it due to presence of sanguinary calculus, mercurial taint, or to perverted conditions of secretions, or its being a manifestation of gouty diathesis, uric acid and its salts having been at the apical ends of roots. The most universally accepted theory at the present time and the cause or combination of causes I believe from clinical experience and family histories to be of local origin and due to diseased activity of the pericementum caused by disturbed nutrition or local irritation.

This disease may manifest itself in various forms and degrees of severity, some being prone to severe hemorrhage on the least digital pressure, and presents various appearances. The gums in some are anaemic, pale and bloodless; in others engorged and distended, with thick margins and liver color, very sensitive to touch, and in many cases are entirely denuded of their epithelieum, with pus pockets extending to the ends of the roots, the roots themselves being more or less exposed and nearly always with deposits of calculus on them. The treatment of this disease we will divide, for convenience sake, into mechanical, surgical and medical.

Mechanical treatment includes the removal of all deposits, thorough cleaning of the roots and ligating or banding them together when very loose.

Surgical treatment comprises opening of pus pockets, removal of the necrosed alveolar process and excision of exposed and carious portions of the roots, extirpation of pulp and canal nerve, making artificial drainage in alveolar and gum tissue when needed, and the closing of chronic fistulae and removal of morbid growths.

Medical treatment embraces the relieving of pain by anodynes given internally and applied topically, syringing out pockets with astringents, antiseptics to reduce inflammation, and stopping discharge, for which there are lots of agents which will answer the purpose. Among those that I use are zinc

sulphate and iodid, formalin and strong solution of potash and silver nitrate for injection. Of agents to cauterize, trichloracetic acid, aromatic sulphuric acid, and twenty-five per cent. pyrozone are among the best. The free use of counter irritants to gums, and the prescribing of a good astringent and antiseptic mouth wash is advisable. If the patient is very anaemic or weak it is necessary to give good tonics to build up the system, as iron, quinine, strychnine and arsenic, or others of that class.

This disease being sometimes associated with or partly due to syphilis, mercurial salivation, rheumatism, gout or other constitutional troubles, it is proper that they should receive due consideration.

In conclusion, I will say that if doctors and dentists would more thoroughly instil into their patients the principles of hygiene and prophylaxis, not only oral but general, there would be less pyorrhoea alveolaris as well as other diseases.

BISMUTH AND OPIUM FOR CHILDREN.

℞ Bismuth subnitrate - - - ℥ij
Fresh mucilage of acacia - - ℥j
Deodorized tincture of opium - mxviij
Cinnamon water, to make - - ℥iv
M. Sig. Teaspoonful in water every two hours; shake.

Sometimes the bismuth subnitrate gives rise to irritation and nitrate poisoning and for this reason the subcarbonate is generally preferred. Perhaps it is not good pharmacologics to put the insoluble bismuth into a solution that requires shaking; it may, therefore, be given alone in a teaspoonful of milk. Phenyl salicylate may, however, be given along with it, e. g.:

℞ Bismuth subcarbonate - - ℥jss
Fac chartulas, No. 20.
Sig. One powder every two hours.
℞ Bismuth subcarbonate - - ℥jss
Phenyl salicylate - - grs. viij
M et fac chartulas No. 10.
Sig. One powder every two hours.

It is much better to order the deodorized tincture of opium alone and administer a drop or more, as deemed necessary, every three or four hours, depending on whether the child is drowsy or not. If less than one drop is required, it is easy for the nurse to put a drop in two teaspoonfuls of water and give the child one of them, which would represent half a drop of the preparation.

If the heart becomes weak, whiskey or brandy may be given. For a child one year old, from 10 to 20 drops, in plenty of water, and given at intervals of two hours, is a large enough dose.—*New York Medical Journal.*

MISSISSIPPI MEDICAL MONTHLY.

E. F. HOWARD B.S., M.D., Editor and Publisher.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

Our good friend Dr. Sutherland has been amusing himself this summer educating the people of Bolivar County in matters pertaining to their health. Most of us have been glad enough to sit on the shady side of the street and take exercise with a fan, but that doesn't suit this energetic young gentleman. Although he claims to have been born in 1848, and is hampered by bodily infimities, the efficient Bolivar health-officer still thinks that to live a day without doing something to benefit his fellow man is a crime unspeakable, so taking advantage of the hot weather he gathered unto himself a band of kindred spirits and on Wednesday of each week descended on some town to hold an institute on the prevention of disease. Here is his program:

1. Education The Most Important Factor In The Promotion Of Health.....Mrs. Dell Kelso Mohlenhoff
2. Malaria—Its Cause And Prevention, With Special Reference To The Mississippi Delta.....
.....Dr. Jno. T. Longino
3. Neglect Of Child's Teeth A Source Of Danger To Its Health.....Dr. H. D. Vardaman, Dentist
4. Throat And Nose Troubles May Affect The Health And Mental Condition Of School Children.....
.....Dr. W. L. Howard
5. What Our School Children Are Being Taught About Sanitation.
(Papers by winners of prizes for essays on this subject.)
.....Miss Emma Trixton
6. Sanitation In Villages And Their Schools, With Special Reference To Tuberculosis...Dr. H. L. Sutherland
County Health Officer and Conductor of Symposium

N. B.—The conductor of this Symposium reserves the right to substitute any other available speaker for No. 6 on this program.

This work, which is in line with what Dr. Sutherland has been doing for years, is certainly worth the while and worthy of imitation. True, we are not all Sutherlands and would probably find it difficult to get together such an array of talent as he has succeeded in doing, but if something of the sort were done in each county it would be of inestimable advantage to our people.

Suggestions Relative To Amendment Of Medical Practice Act In State Of Mississippi.

The State Board of Health to have seven members nominated by the State Medical Association, and appointed by the governor. Their duties to be those appertaining strictly to health and quarantine matters in the state as now provided by law.

A new board to be termed "State Licensing Board" to be appointed, consisting of seven members, to be named directly by the governor; three of these members to be representatives of schools other than that termed "Regular". This licensing board to have all power and authority now lodged in State Board of Health relative to the licensing of all persons who hold themselves out as healers of the sick.

The practice of medicine shall mean to publicly offer or attempt to treat or cure real or imaginary ills of the human mind or body by whatever method whatsoever, whether for gain or otherwise.

All persons offering themselves as physicians or healers must stand an examination, as it is at present prescribed in Section 3682 Code 1906, and must be graduates of a recognized institution of their particular cult.

License may be revoked at any time by a majority of the board, upon proof of immoral conduct, excessive use of alcohol or narcotics or performing abortion for pay.

Females practicing mid-wifery must stand a suitable examination before health officers in each county before being granted a permit to do so.

H. M. Folkes.

The Committee On Public Policy And Legislation will meet at the Capitol at Jackson Tuesday, Oct. 10th., at 2 P. M. to consider bills to be introduced at the 1912 session of the Legislature.

Mississippi State Board Of Health.

Some Statistics Relative To The Work Of The Mississippi State Board Of Health During The Period Beginning June 1st. 1911 and Ending June 30th. 1911.

Literature Printed and Distributed.

(a)	Placards on tuberculosis for public schools (Printed for and distributed through the Department of Education)	20,000
(b)	Bulletins on tuberculosis	21,000
(c)	Leaflets on tuberculosis	50,000
(d)	Bulletins on hookworm disease	15,000
(e)	Hookworm circulars	45,000
(f)	Bulletin on sanitary privy	15,000
(g)	Bulletin (general)	12,000
(h)	Bulletin on improved type sanitary privy (LRS)	12,000
(i)	Bulletin on state's duty in the care of public health	12,000
(j)	Bulletin on clean milk	12,000
(k)	Leaflets on sanitary privy	25,000
(l)	Leaflets on the house fly	10,000
(m)	Circulars giving facts of sanitary importance	5,000
	Total number of pamphlets written and distributed to the people	254,000

Newspapaer Articles.

(a)	Clippings collected at central office, representing only a small proportion of the total written	275
(a)	Newspaper articles written by men of staff (Health Bulletins.)	250
(c)	Sanitary issues of county newspapers, collected at central office	19

Note: (Subdivision c) From one to two pages of the paper was devoted to descriptive matter and allustrations upon sanitary subjects.

Correspondence.

Personal letters (Central Office) approximately	2,500
Circular letters (Central Office) approximately	5,000

Interviews.

(a)	Editors	106
(b)	State, county and municipal officers	108
(c)	Physicians	527

Addresses Given.

(a)	To physicians	21	Attendance	625
(b)	To schools	338	Attendance	34,010
(c)	To teachers	32	Attendance	4,810
(d)	To public	399	Attendance	61,095
(e)	To boards, etc.	20	Attendance	360
	Total	810	Total	100,901
	Number schools inspected			350

(Many schools were inspected without clinical or microscopical examination for hookworm.)

PUBLIC HEALTH EXHIBITS.

(a) State Fair (10 days). Attendance..... 47,173
(1) National Tuberculosis Exhibit. Attendance by actual record 27,173
(2) Board of Health Exhibit. Attendance..... 20,000
(b) Board of Health Exhibit at Harrison County Fair (10 days). Attendance 10,000
(c) Board of Health Exhibit at Kosciusko (7 days). Attendance 2,000
(d) Board of Health Exhibit at Durant (7 days). Attendance 2,000
(e) Board of Health Exhibit at Yazoo City (6 days). Attendance 2,500
(f) Board of Health Exhibit at Lexington (5 days) Attendance 1,200
(g) National Tuberculosis Exhibit at Columbus, Meridian and Natchez, ten days each.....
Attendance 35,000

Stereopticon lectures were given from two to four times per day during the period of each exhibit at the respective places.

ROUTINE MICROSCOPICAL EXAMINATIONS FOR HOOKWORM DISEASE.

(a) College students representing seventy-seven counties in the state.
No examined..819 No. infected.232 Percent. of infection, 39.4
(b) Orphanage pupils.
No examined:
(1) Boys .. 66 No. Infected..42 Percent. of infection, 63
(2) Girls .. 99 No. infected..38 Percent. of infection, 38

Total ..165 Total.....80

PUBLIC SCHOOLS.

	No Examined Microscopically.	No Infected.
Attala (Chiefly Kosciusko)	80	8
Clarke	114	47
Covington	504	344
Forrest	181	122
Hancock	4	4
Harrison	149	126
Jackson	79	32
Jefferson Davis	283	175
Jones	1,122	838
Lafayette	199	33
Lamar	5	5
Lawrence	194	130
Marion	1,472	1,303
Monroe	118	67
Neshoba	198	146
Newton	296	167
Pearl River	396	258
Perry	59	33
Rankin	435	223
Scott	539	33
Simpson	511	420
Smith	90	77
Totals	7,028	4,786

Percentage of infection, 68.

Number of cases of Hookworm Disease treated: (approximately) 12,000.

(NOTE)—The above statistics have been worked out carefully and wherever an estimate is necessary it has been based largely upon records in the central office and is indicated by the word "approximately".

Society Proceedings.

Clay-Lowndes-Oktibbeha Medical Society met in the City Hall, Starkville, Sept. 28th. at 1 P. M. to discuss the following program: "Railway And Surgical Shock: Indications And Contra-Indications In Management", W. R. McKinley; "Report Of Cases", W. L. Ervin; "Malaria", J. E. Murphy; "Constipation", J. S. Montgomery; "Pellagra: Report Of Cases", W. W. Boyd; "Some Experience And Observations Of Pellagra", S. S. Thomas. Dr. McKinley's paper was previously read at the sixteenth annual meeting of the Association Of Surgeons Of The Southern Railroad at Charlotte, N. C., May 1911, and was repeated on this program by request.

Edw. Lehmberg.

East Mississippi Four County Medical Society met in regular session at Amory July 18th. at 2 P. M. in the offices of Drs. Bryan and Burdine. Owing to the fact that it was a very busy time, both professionally and politically, the attendance was unusually small. Dr. Bryan presented a case of aneurism of the ascending aorta which was examined and discussed by all present. Other clinical cases had been booked for the meeting but failed to materialize. After business the visitors lunched with the Amory physicians at the T. P. A. Hotel.

F. J. Underwood.

Tri-County Medical Society met at the City Hall, Brookhaven, August 3rd., President J. M. Dampeer in the chair, D. W. Jones, secretary, and the following other members present: O. N. Arrington, J. T. Butler, Hy. Flowers, W. H. Frizell, J. H. Johnson, T. K. Magee, N. A. McLeod, F. V. McRee, T. J. Safley and V. B. Martin. Malaria was the general subject, and papers were read by Drs. McLeod and Butler. Also papers prepared by Drs. Klotz and Lockwood were read by the secretary. A general discussion followed, in which several important points were developed. Dr. Jones, assisted by Messrs. Lewis and Sartin, internes at the Sanitarium, gave a microscopical demonstration of several different forms of malarial parasites. After some routine business, the society adjourned to meet at Brookhaven, at 2 P. M., October 3rd., at which time the general subject will be obstetrics.

D. W. Jones.

Book Reviews.

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Vol. XVI. NOVEMBER 1911. No. 7.

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MISSISSIPPI MEDICAL MONTHLY

VOL. XVI. NOVEMBER 1911. No. 7

*PRESIDENT'S ADDRESS.

R. L. MERCER M.D.,

SHELBY.

Before taking up the few points to which I want to call your attention, I desire to express my appreciation for the honor you have conferred upon me, and to avail myself with pleasure of this opportunity to make my grateful acknowledgments for the courtesies and friendly attentions which I have uniformly experienced from the members and friends of the Clarksdale and Six Counties Medical Society during the few years that I have been associated with you. I shall ever cherish this honor with the most grateful recollections, and look back upon it with proud satisfaction.

I desire also to express my appreciation of the work of our efficient secretary, Dr. Pierce, in securing men for the program who would make our society a success, doubtless the best of any local organization in the state, and commend him to your further consideration.

I want to thank the physicians of Clarksdale for their pains and efforts in securing this handsome club for our meeting, and arranging our banquets, around whose festal boards the time is always pleasantly spent.

To our visiting physicians I would not forget to express my very hearty appreciation for your presence, papers and discussions, and in behalf of this society bid you always a hearty welcome.

The subject of medicine and surgery I leave to other members of this body.

The first point I wish to call your attention to is our hearty co-operation with the State Board of Health and the county health officers in the six counties, "to provide for the collection and publication of vital and medical statistics in the several counties, and promote public health interests generally." Let's answer their letters and requests, give them all available information, report our tubercular cases, treatment and results.

*Delivered before the Clarksdale and Six Counties Medical Society.

The insurance question has been spoken of by several members of this association, and inasmuch as we can get the five dollar fee for each examination for "old line" companies, the source from which it comes should not be considered, in that many agents who have materially aided us are now injured in their business relations by our existing ordinances. I ask your consideration particularly to this question. Perhaps there is no other factor that is conducive of better results than the high standard of medical ethics that exists in our district, and our fee system comes under that head. I quote you a section from the Principles of Medical Ethics: "Some general rules should be adopted by the physicians in every town or district, relative to the minimum pecuniary acknowledgment from their patients; and it should be a point of honor to adhere to these rules with as much uniformity as varying circumstances will admit." From some sections it has come to me that there is lack of uniformity along this line.

This Association has a fee bill; if it is not suitable in each town or district, I would ask you to formulate one that is applicable.

The subject of legislation deserves our careful consideration; and to get at the course suggested it will be necessary for me to quote from the president's address last year:

"Let the legislative committee get out its scheme of proposed legislation, submit it to the Association at its next meeting and get its endorsements with such modifications as may seem proper; then have the same submitted to the county societies with the request that each society have its individual members sign the printed recommendations of the State Association; then let the memorial be presented to the candidates for the legislature for their approval or disapproval. We can then get some committals which will be of weight when the legislature meets the following January. In other words, get our legislators committed in advance, the committals being amply justified on the ground of such a memorial in each county."

I wish to call your attention to the above paragraph especially, because we will not meet again until after the election of the legislature.

The wheels of the machinery of legislation are slowly turning, but that one pertaining to medical legislation has a dry or worn-out bearing; but let us continue to pour on the oil of interest, or bush it with the demands of necessity, until there is a law on our statute books whereby Mississippi will be recognized as in the front ranks of our profession, and all ap-

plicants for license be men not only of character, but graduates of some reputable medical college.

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*MISSISSIPPI MEDICAL PRACTICE ACT AS COMPARED WITH OTHER STATES.

T. A. CARDER M.D.,

LULA.

I do not expect to advance new ideas or detain you with a long paper, but hope to remind the members of our profession of many neglected duties. We are living in an age when it is proper to live, and when all are interested in medical matters. It is not that medicine has in any sense of the word revived, but that she has simply changed her attitude of observation. After having devoted herself during many long years to the verification of symptoms, to the research of anatomical lesions, to the study of pathological physiology, she comes at last to study the origin of disease.

What is characteristic of these modern days, so far as medicine is concerned, is the high place we assign to the study of the origin of diseases; but I wish now to call your attention to the other or legal side of the profession: that is, the Mississippi Medical Practice Act as compared with the other states. This is one of only three states in the union that admits non-graduates to their examinations and with which no other state will reciprocate.

I have recently had occasion to correspond with quite a number of the different State Boards as to reciprocity and from each (and especially Louisiana and Texas) came the reply that they could not reciprocate with us because the requirements of our Medical Practice Act were not up to the standard, in that our State Board admitted under-graduates to its examinations. No doubt but that there are some of you who have had this same experience, that the certificates of our State Board would not be recognized by other states, and right here I wish to call your attention to a letter from Dr. H. M. Folkes, of Biloxi, in the February number *Mississippi Medical Monthly*, page 205, in which he relates a case of one of our old practitioners, whom he knew to be well informed from a practical standpoint, yet who felt, and probably was not able to stand such an examination as is presented to an applicant for license without con-

* Read before the Clarksdale and Six Counties Medical Society.

siderable studying, which his physical condition would not permit, and, of course, he could not compete with the younger men just from college in these examinations. He is, by the way, an ex-member of the Mississippi State Board of Health. I merely mention this to more forcibly bring before you the necessity of enacting a law which will place Mississippi in a position for reciprocity and give us equal rank with other states in medical education legal qualifications of her licensed physicians.

I doubt seriously if there is a member of this Association who has been in active practice as long as ten or fifteen years, who could pass any of the state boards with credit. Now, without reciprocity, should any member of the profession in the state desire to change his location to another state, he would be compelled to undergo an examination the same as is put up to the student or young man who is fresh out of school. Now, I challenge any of you who have been in active practice for ten, fifteen or twenty years to compete with him from a text-book standpoint, on which all state board quizzes are based, but take the older members of the profession from a practical standpoint, and none of them would fail on an examination (possibly). Such, though, is not the case when we come to stand a state board quiz; the old practitioner is classed with the young man just out of college, fresh with theory, and all are required to make a grade of seventy-five per cent. or lose out. This, I think, is unjust and I think any citizen of the United States who has a diploma from a reputable medical college and has passed a written examination before a state board of health should be allowed to practice his profession in any part of the United States on presentation for registration a license properly certified to as to his identity.

Now, Mr. President, we claim that there is a solution for all questions; so it is with this. If it is the desire of the medical profession of the state of Mississippi (of which we are the largest component organization) to be in line for a medical practice act with the other states, it will have to be done through an act of the legislature, and less memorials and lobbying committees, as has been suggested and practiced by the State Medical Association.

Now, in conclusion, I wish to state that we are shut out from reciprocity with the other States (as Louisiana and Texas state board secretaries stated to me) because we admit non-graduates to our state board examinations and do not require a diploma from applicants for a license.

Now, Mr. President and gentlemen of the Association, why not get together and try to send a doctor to the legislature from

some of these six counties. It is true that it is an office generally thought of as of little or no importance, but at this time, when we of the medical profession are so anxious to get such medical laws enacted as will not only conserve to the interest of the doctor, but to the welfare of our citizenship, we should look upon the office with more seriousness and see that a doctor is elected even though he be a sacrifice. And I hope each member of this Association will think this matter over seriously and do what he can to get a doctor in the next legislature, that we may get a medical practice act, the requirements of which will be equal to that of any of the other states.

I also think that we would do well to discuss this matter before the state medical association, and try to awaken the doctors over the state to the importance of our medical laws and our professional standing among or with the other states of the union.

I should be glad to hear from some of the other members along this line.

---

*VARICOSE VEINS WITH SPECIAL REFERENCE TO SCHEDES' OPERATION.

E. C. PARKER M.D.,

GULFPORT.

There is no doubt that the calibre of the varicose veins are dilated, nevertheless veins that are dilated are not necessarily varicose; a difference is therefore recognized. This difference consists in the condition of the valves. In the former (varix) the valves are insufficient; in the latter (dilatation) they are not. In the varix the walls are irregularly thinned, lengthened and tortuous. In dilatation the walls are more or less thickened. A striking example is in varicocele that is present on the left side in about ten per cent. male adults; here the veins are valveless and when rolled between the fingers and thumb, or compressed, furnish the well-recognized sensation of a bag of fish-worms and when you excise them, for the radical cure of varicocele, the walls are always uniformly and sometimes enormously thickened.

Insufficiency of the valves is caused by a stretching of the walls of the veins so as to separate their free edges, leaving an interspace that permits of the regurgitation of blood in a direction opposite to the normal current; in consequence the column

*Read before the Harrison County Medical Society.

of blood has no longer support against gravity and does not flow normally into collateral channels.

When interrupted in its more direct course the valvular insufficiency is a potent factor in progressively thinning the vein walls and adjacent skin.

Causes of varicose veins of the lower extremity are thrombus of large veins following typhoid or other long continued fevers; injury of the pelvis, thigh or leg, lessening the nutritive power; local pressure in the pelvis or abdominal tumor or fecal accumulation (this always affects the left leg); long standing occupation affecting the long superficial internal saphena; congenital defect in the arrangement of the valves.

Varicose veins of the upper extremity are caused by occupation requiring overuse. Washerwomen who work regularly and use their hands instead of wringers. Men who work at brick kilns, pitching brick in the erect position. Tennis and and baseball players sometimes suffer symptoms.

The early symptoms are pain in a muscle or group of muscles in an unusual locality of the arm, usually attributed to sprain; to diagnose such a case, make a slight compression with a bandage around the arm near the axilla and it will immediately make a varicose vein prominent and, to prove your correctness in diagnosis, apply a roller bandage and the movement of the arm will be made without pain; afterwards apply an appropriate well-fitting elastic bandage or stocking; but in extreme cases it may be necessary to operate.

In varicose veins of the lower extremities the symptoms are cramping pains upon rising in the morning, passing off later in the day, and late in the evening a sense of fullness and heaviness, with more or less pain in one or both legs.

Inspection rarely reveals superficial varicose veins in the beginning, except perhaps a few slight varicosities near the saphenous opening and upon the outside of the thigh, in the popliteal space, on the fibular side of the leg or behind the ankles, and all or a part of them may be absent. In some cases slight oedema of the foot and ankle come on later in the evening, possibly only noticed by a loose shoe feeling tight at night.

Varicosites of the deeper veins are recognized now more often than formerly.

In the beginning of varicose veins of the lower extremities the differential diagnosis between gout, rheumatism and varicose veins must be made.

The sense of fullness and heaviness that is experienced is due to the bursting of veins, to the wounds of the cuticle by the finger nails in scratching (to allay the itching after lying

down), to an accidental contusion or abrasion, to the presence of phebolith that causes molecular death by pressure or by becoming septic.

The methods of treatment of varicose veins of the lower extremities are numerous and vary quite a bit. Injection, acupressure, ligating and excision are the most popular methods.

Paul Vogt recommends cutaneous and subcutaneous injection of ergotin into the perivascular tissue. Injection of absolute alcohol or a few drops of pure carbolic acid has met with quite a good deal of favor. Care must be taken to avoid any direct injury to the vein. Ligation of the veins has probably met with more approval by surgeons than any other method. Veins like arteries may be ligated in their continuity or divided extremities.

Schede's method of operation is as follows. He makes a circular incision around the leg down to the veins, which he exposes for a distance above and below by means of circular flaps, the vessels are tied by two ligatures and the portion between is excised and the flaps replaced, borders united and the limb dressed and confined as usual. Care should be taken not to divide the long and short saphenous nerves.

I am partial to the Schede operation somewhat modified and will here give an outline of some cases operated on by this method:

Case I. Miss C., age forty-seven, white, housemaid and cook. Both legs badly varicosed, so much so that it would have been very difficult to have dissected out the varicose veins. I made a circular incision (just above the junction of the upper and middle thirds of the leg)) around the leg (the first incision of an amputation), caught up the ends of the veins and ligated them. After removing the tourniquet and seeing that all bleeding was checked, I sewed up the wound with silk-worm gut, applied a dressing and put the patient to bed. Stitches were removed on the tenth day; patient kept in bed three weeks and left the hospital within four weeks apparently perfectly well. I kept up with her for three years and she was still perfectly well.

Case II. The wife of a physician, very stout, weighing about two hundred and seventy-three pounds. Both limbs were badly varicosed two-thirds the way upon innner side of thigh (owing to immense amount of adipose tissue). I was afraid to attempt but one limb at a time. The lower operation was the same as above described. But in addition I went above the varicose veins in the thigh and made an incision about two-thirds around the thigh, completely severing the superficial

veins as in the lower operation; sewed up the wound and dressed it. In two weeks I treated the other leg the same way. Prior to the operation this lady was unable to get around and look after her home and suffered continually, but since operation has been perfectly well, suffering neither pain nor inconvenience,

Case III. Male, age thirty-eight, farmer. When I first saw him he had two large varicose ulcers on the left leg, having been treated a long time without results. He immediately consented to an operation. As a precaution to keep from infecting my field of operation I wrapped the leg well above the ulcers with a bichloride towel, then proceeded to operate as before.

I was careful not to let the dressing of the ulcer come in contact with the dressing of the wound. He was dismissed from the hospital at the end of the fourth week, the wound entirely well and the ulcers while not well were very much better.

I saw him two months later and he was perfectly well and at his usual work without pain.

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*"A REPORT OF CASES."

H. C. BUCK M.D.,

FRIARS POINT.

I wish to state that I report these cases because I think there are some interesting features in them and also because they serve to illustrate conditions that often confront the country doctor, who must, as far as possible, "be all things to all men", not only in his professional life but in his general conduct to his fellow-man.

On July 24th. 1909 I received a note from a widow lady requesting me to visit a negro woman on her plantation. She wrote that the negro had recently given birth to a child and she feared she was in a dangerous condition. On visiting the negro I found she had given birth to a child on July 22nd. about 7 P. M. There was no one with her who knew how to manage a case of this kind. The woman present did not know enough to tie and cut the cord, but when it came to delivering the placenta they proceeded in a unique and very original manner. They forced the poor woman to remain upon her feet the greater part of the time, occasionally allowing her to sit on a chair for a short while but never allowing her to lie down.

* Read before the Clarksdale and Six Counties Medical Society.

One of the women said they wanted to make her "drap" the after-birth. About seven o'clock next morning, or after about twelve hours of this torture, they made her "drap" it, after which they very kindly allowed her to lie down and for several hours the poor woman slept the sleep of exhaustion. When I saw her, about forty-eight hours after delivery, I found her with a full bounding pulse, very great swelling and tenderness over the whole abdominal region, vagina hot and dry, no discharge whatever. I made the woman boil some water; to a half gallon of this I added two teaspoonfuls of salt. When it was cool enough for me to bear my hand in it I thoroughly washed out the womb and vagina. I then gave her a hypodermic of *H. M. C. tablets full strength, told the woman to keep hot cloths over her stomach and bowels all the time and to give her a full dose of salts that night and also to wash her that night and the next morning with the warm salt water. I visited her the next day, just twenty-four hours after my first visit, found the discharge normal, swelling and tenderness of gone and the woman recovered without further trouble.

On August 16th. 1910 a negro man came for me to visit his wife. Said she was having "fits". Upon arrival at his home I found his wife in labor, with an old negro "Granny" officiating. I use the word "officiating" advisedly. She said the woman had had several hard fits. Examination showed labor well advanced, the head being low down in the pelvic cavity, there being no swelling about any part of the woman, no other symptoms of kidney trouble except the spasms. I decided these were caused by excitement and nervousness. I gave her a hypodermic of †H. M. C. Co. half strength and left a tablet instructing the old woman to give it to her in three hours if she was still restless and if she had any more "fits" to let me know and I would come and deliver with the forceps, but I did not want to do this if it could be avoided. The man came to my house early the next morning and reported his wife as doing well, having good pains, etc. He said that about two hours after I left his house the old woman gave his wife the tablet I left and that the old woman and his wife slept the balance of the night. About nine o'clock P. M. the man came for me and said the old woman said I would have to come and help her. On my way to his house I asked him if the old woman could not get the baby. He said the baby had been born about

*Hyoscine Hydromide 1-100
Morphine Hydromide ¼
Cactin 1-67

†Hyoscine Hydrobromide 1-200
Morphine Hydrobromide ¾
Cactin 1-134

two hours but the old woman could not get the afterbirth. When I got there and examined the woman I found a child, head presentation and conditions of labor about as I examined her the first time. I told the old woman if she had taken the other child perhaps she could have delivered the afterbirth. She said "she knowed thar was something wrong wid dat nigger; she had been cuttin' up scanlus for two hours". I delivered the child and placentas (there were two placentas and two cords) and the woman had an uneventful recovery. I have given this case a great deal of thought and have wondered if the old woman had a case of placenta previa with the placenta of the first child which was finally pushed aside by the tumbling "scanlus" conduct of the woman, or whether it was simply a case of pure ignorance.

On May 19th. 1910 I was called to see Steve, a robust negro man about twenty-seven years of age; found a well developed case of pneumonia with as unfavorable surroundings as could be well imagined. The negro had just hired to a man to work for him and until he could provide a better place he put the negro in his feedroom with a cot to sleep on. This room was very dirty and open with cracks in the walls from one to three inches wide. The weather was wet and unusually cool for the season, the rain blowing clear through the house more than half the time. I prepared him some medicine and left him to take it as best he could, as there was no one to give it to him. Upon visiting him the next day I found his condition very serious and told the gentleman he had better send the negro to the county poor house, as he would be comfortably taken care of there and would die if he remained in his present quarters. The negro was violently opposed to going to the poor house and that night after nine o'clock he got up and put on what clothes he could find in the dark, leaving off one shoe and his hat, and in this condition he wandered in the rain and mud until about eleven o'clock he found his way to the livery stable where he had previously worked. The proprietor made him go to bed and telephoned me that the negro was there and asked what he must do. The negro had taken his medicine with him and I told the gentleman to give him his medicine according to written directions, but I thought the negro would die. I visited him early the next morning and while his condition was bad it was not as bad as I expected to find it. He rested quietly during the day and the night following. The next day, being left alone, he ran off again and was found at the railroad depot, at least a half mile from the livery stable. He was put in a hack and sent to the stable and I was called. I

found him completely prostrated, cold, clammy perspiration all over the surface, almost pulseless. I thought him in a dying condition, but I gave him a hypodermic of one-fortieth grain of strychnine and one-one hundredth grain of nitroglycerine. In about thirty minutes he vomited fully a pint of bloody mucus, etc., and immediately rallied and improved. I then told him if he did not stay in bed and take care of himself he might die and go to Hades; I would not fool with him any more. After I gave him this kindly admonition he took care of himself and had an uneventful recovery.

On May 23rd. I was called to see W. C., in physical build and age almost a counterpart of the other negro. He, too, had a well developed case of pneumonia. I treated him for a day or two when on visiting him one morning I found his condition very much worse. Upon investigating the cause his wife said she was left alone with him the night before and about midnight he got up and said he was going to the pump and get some water. When she remonstrated and tried to hold him he very promptly knocked her down and went out in the cool night air and rain, absolutely naked except an undershirt that reached very little below his waist. In this condition he went to the pump, drank his fill of water and after walking around a while went back and got in bed. Strange to say, his bad symptoms had all disappeared by the next day and he recovered without further trouble.

THYMOL ($C_{10}H_{14}O$)—ITS SOURCE, PHYSIOLOGICAL ACTIONS AND THERAPEUTIC INDICATIONS.

A. O. BEADLES M.D.,

STONEWALL.

In writing this paper on Thymol, I have merely touched upon its source and physiological actions, but have dwelt more fully upon the therapeutic applications.

Thymol is a phenol occurring in several different volatile oils, but it is obtained for commerce chiefly from the oil ajawan seed, the fruit of phychotis ajawan. It is also obtained from the oils of thyme, monadra didyma, monarda punetata and ammi capticum.

After being extracted from these oils by a chemical and physical process, it appears in large, colorless translucent crystals of the hexagonal system.

Thymol is a local irritant and paralyzes the terminal sensory nerves of the skin and mucous membranes. Internally

it is ascertained that twenty to thirty grains in twenty-four hours is necessary to produce very distinct effects. When given in this amount it induces a sensation of heat about the epigastrium, but rarely causes nausea and vomiting. Given in large doses, from thirty to sixty grains, it causes, in about half an hour to an hour, sweating more or less profuse, but less than that produced by salicylic acid or jaborandi. The sweating is coincident with the fall in temperature and I have seen in a few cases, followed by rigors, evidence of great weakness and threatened cardiac failure. At the same time the patient complains of singing in the ears, deafness, constriction of the forehead, and is often troubled with a frequent diarrhoea. The urine is often increased in quantity and presents a dark, greenish hue, as if it contained blood. I had microscopical examinations made on several specimens of this urine but not a trace of blood could be found. This color of the urine is perhaps due to the presence of a decomposition product of thymic acid, and in part of thymol itself, for a portion of that taken escapes unchanged (Blum). The continued use of even small doses of thymol is said to interfere with nutrition and emaciation results. Kussner found that thymol has the power of dissolving the red blood corpuscles. Thymol lowers arterial tension and reduces reflex action. The nerve-centers of the cord are paralyzed by large doses. Toxic doses in animals cause death by respiratory failure.

Thymol, therapeutically, is employed as an antiseptic and anthelmintic. It has been recommended also as an antipyretic, but this use should be condemned, for the large doses required to effect any considerable reduction of temperature, the sweats, chills, and depression of the powers of life which are thereby caused, renders its use prohibitory.

Thymol has been recommended in diseases of the mouth and throat, and I have used it with success in mouth-washes for stomatitis; in gargles, or in form of a spray, for tonsilitis, diphtheria and other inflammations of the throat. For this purpose a solution varying in strength from one to ten parts in one thousand may be employed. It is also used as an antiseptic dressing in wounds and to correct the fetor of mucus discharges.

As an irrigation in leucorrhoea, otorrhoea and gonorrhoea, a solution of one to three thousand is said to have given good results, though I have never used it in this capacity.

In gastric and intestinal catarrh thymol has given me good results in resisting fermentation, at the same time stimulating digestion.

In the summer of 1909, I used thymol in eight cases of diarrhoea and dysentery of various sorts, all of which, except one case of dysentery, were benefitted in from two to five days. When contrasted with about an equal number of cases treated

without thymol, the good results were noticed in the diminution of the daily number of stools, an absence of mental excitement, and especially by the clean, moist tongue presented in nearly every case.

During the autumn of 1910 I administered thymol in three cases of typhoid fever treated with seemingly good results. The drug diminished the tympanites, the stools became less frequent, the cerebral symptoms diminished and a moist and clean tongue appeared. The drug also hinders the formation of offensive matter in the feces and reduces the excretion of urea. In these cases of intestinal disorders including the three patients with typhoid fever, I administered the thymol in capsules every six hours.

Thymol is most efficient, and almost a specific, in uncinariasis, or hook-worm disease. The drug may be given in various ways but I have gotten best results from the following way of administration: after having placed the patient upon fluids (milk and broth) for about eighteen hours, administer three powders containing calomel, soda and phenolphthalein (*a.a.* one grain to each powder) two hours apart, so that the last dose of the calomel comes about 5 P. M. The patient may be allowed his last broth and milk at 6 P. M., and at 8 P. M. administer a tablespoonful of epsom salts dissolved in one-half pint of water. After the salts is administered the patient is not allowed even broth and milk, and the thymol is administered the following morning, in two doses, two capsules of fifteen grains each, given at 4 A. M. and repeated at 6 A. M. At 8 or 9 A. M. give a tablespoonful of epsom salts. We should get good results by 3 P. M., when the patient may again be allowed broth and skimmed milk, and at 6 o'clock food may be given.

In one week if the ova is found in the feces, the treatment should be repeated. I have found it necessary to give the treatment from three to seven times.

I have used thymol in two cases of taenia saginata (beef tape worm, the most common form) with success. The drug was used in one of these cases three different times before the cestale (worm) was expelled, but I am sure my failure in the first two treatments was due to an insufficient size of the dose. In these cases thymol was administered after the patient had been on liquids (milk and broth) for forty-eight hours. One patient was given sixty grains with success, the other (the one given the three treatments) was first given sixty grains, then seventy, then ninety grains, which expelled the worm.

The method of administration of thymol in tape-worm is about the same as that I have gone over in the treatment of hook-worm, except in the cases of taenia the doses must be larger, and the patient should be placed upon liqiud diet at least forty-eight hours before beginning treatment.

As an intestinal antiseptic, thymol should rank among the

first. As an anthelmintic in the treatment of uncinariasis and taenia saginata, it has no equal.

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*THE VALUE OF ENEMATAE IN GENERAL PRACTICE.

L. B. SPARKMAN M.D.

CLEVELAND.

I offer this subject for consideration because I feel that it is often neglected or its value forgotten. It is a remedy always within our reach and when properly given is without danger or bad effects, will not interfere with any other treatment, and is usually prompt in its results.

The indications for enema are varied, and it can be made to serve a great many different purposes. We will first consider the simple enema which is most commonly used to unload the distended bowels. For this purpose the water should be tepid or just about the normal temperature as this causes the least reaction, and should be given in a recumbent position with hips somewhat elevated, or the knee-chest position. The enema will gravitate to the transverse and ascending colon and soften the hard dry fecal masses which we sometimes find impacted in the colon, and simulating small blighted nuts glued together with mucus. The smallest quantity of water that will suffice to to soften and dislodge these masses and thus aid in prompt evacuation, is sufficient. One quart in such cases should be the maximum until the colon is partially or completely emptied, as large quantities of fluid will produce atony by overstreching. After breaking up these fecal masses and there is atony existing, the peristalsis may be stimulated by first inserting a rectal tube and withdrawing the portion that has not been absorbed, and injecting another quart containing an ounce of glycerine, or a tablespoonful of molasses, or a teaspoonful of salt, or one drachm turpentine, or yellow soap suds. Either of these will irritate the mucus membrane and excite peristalsis.

Just here I wish to report a case to which I was called some years ago. A male, age about fifty, who had atony of the bowels and impacted caecum. His bowels were distended and had not moved for about forty-eight hours. Nausea was so great that he could retain nothing in his stomach; temperature about 99 4-5° F. I gave calomel in two grain doses with bicarbonate of soda every hour until six were given and, the nausea being partly allayed, I then gave teaspoonful doses of

*Read before the Clarksdale and Six Counties Medical Society.

hyposulphite of soda every hour for several hours, without results. In the small amount vomited I noticed a fecal odor which was very suspicions of intussusception, and I diagnosed "obstruction of the bowels" and resorted to enema. The first quart returned slightly stained, the second quart was retained. I then made half a gallon of yellow soap suds and placed in a fountain syringe, to which I attached a colon tube and inserted it without resistance through the descending and transverse and into the ascending colon. Then holding the fountain a little above the patient's body, which was recumbent, the flow was without force and before the fountain was emptied he cried "Enough! Enough! I must get up". So I withdrew the tube and he passed at least one gallon of a general mixture, lumps included, and made a speedy recovery.

In the treatment of constipation the enema serves a great purpose when judiciously employed. If the constipation is caused from atony due to loss of nerve sensibility, we should alternate with the hot enema at 110° F., withdrawing one before using the other. This should be used at night just before retiring and repeated several times or until results are obtained. The reaction following increases peristalsis, removes quantities of decomposed matter and toxins, increases the portal circulation, stimulates the kidneys, and produces a flow of fluid toward the intestines. Thus a much smaller quantity of water will serve our purpose in cleaning out the colon and reducing the toxins.

In cases of suppression of the urine or shock, I would prefer the graduated enema, beginning at a temperature of 125° F., of a normal saline of from one to three pints. It will increase the blood pressure, accelerate the heart's action, and in a short while the patient will often, but not in every case, void large quantities of urine. I would prefer this to any one drug treatment, but we should always realize the seriousness of such cases and call to our service other stimulants and diuretics.

In flatulent colic due to pent up gases or ferments from undigested food, or enteralgia, the hot rectal enema will often give good results. For this purpose we should use about one quart of water at a temperature of 110° F. and two drachms of bicarbonate of soda. This will neutralize the acids caused from fermentation and cleanse the lower bowels.

This same enema may also be used to advantage in cholera morbus, diarrhoea, cholera infantum, or dysentery, given in quantities in proportion to age, to remove the irritating and infectious material and reduce the frequency of stools; and

after its discharge a small cold enema may be given, to which may be added any necessary astringent to be retained. But where there is much pain and frequent stools, or tenesmus, the enema will not be retained, but will serve the purpose of cleansing; and after its discharge, to relieve the pain and tenesmus and reduce the mucus stools, I would use starch water, one to three ounces; tincture of opium, five to twenty drops, and carbolic acid, one to four drops; mix and inject to be retained, and repeat after stools or as necessary to relieve. The quantity of each would depend upon age, etc., and will invariably give the patient more or less relief, but may have to be repeated several times during the day.

In conclusion, I will say that the enema can be used to advantage in many other diseases at some period of their duration, and which time will not allow me to discuss in this paper, as it has already become more lengthy than I intended it should be, so I will leave the subject for your consideration.

Personals.

Dr. J. E. Baylis of Hattiesburg has entered the United States Army.

Dr. W. H. Doty of Biloxi has gone to Texas.

Dr. W. A. White has settled at Rodney, Jefferson County.

Dr. E. Dill of Hattiesburg has moved to Muskogee, Okla.

Dr. H. D. Webb of Grace, vice-president of the Issaquena County Medical Society, has gone to New York where he expects to make his home. Dr. Finlay, formerly of Greenville, succeeds Dr. Webb at Grace.

Dr. A. Holt has returned to his old home at Russum, Jefferson County.

Dr. G. W. Stephens of Meridian, an assistant in the Insane Hospital, has gone to Phoenix, Arizona.

Dr. A. W. McNeal has left Money, Leflore County, for the west in search of health.

Dr. E. K. White of Florence has moved to Biloxi.

Dr. J. B. Gallaspy, formerly of Pelahatchie, is now living at Newton.

Dr. C. H. Tennent has moved from Como to Oakland.

Dr. B. T. Orendorf has moved from Greenville to Rolling Fork.

Dr. H. A. Gamble of Greenville was married to Miss Kitty Innes Starling Oct. 31st. The *Monthly* joins with Dr. Gamble's many other friends in wishing them all happiness.

MISSISSIPPI MEDICAL MONTHLY.

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S. MYERS M.D., Business Manager.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

What is a publicist? We confess to some ignorance of the term, and our knowledge is not increased by reading a pamphlet by one W. L. Harris which, with two letters by Solicitor McCabe of the Department of Agriculture to Dr. W. H. Wiley, has just reached us and we presume all other medical journal editors. These two letters of McCabe's are gems. Did space permit, we would print them in full, not for their worth but so the medical profession of Mississippi might judge from the crass ignorance displayed the kind of man politics had placed in charge of administering the Pure Food and Drug Act, and further that our confreres could wonder how a man could write such an insulting, insinuating, and dictatorial letter to a fellow official of high standing and get away with it. We congratulate McCabe's family on the choice of a residence north of the Potomac, coupling our felicitations with the advice that if they desire to retain the husband who is a good provider, and the father who is affectionate, they will gather at his footstool in the cool November evenings and caution him against writing letters of this type to a Southerner. In the language of politics, it would cause a vacancy in the Department which would be hard to fill.

It tickles the fancy to read of the Solicitor referring to Jaynes' Vermifuge and others as drugs; his strictures on Dr. Wiley for not bringing such "drugs" to book for their outrageous therapeutic claims, after the Supreme Court had held that the Food and Drug Act did not cover therapeutic claims, are joy-compelling. But then to a solicitor who was able to work the Denver meeting and have a scientific question like the use of sodium benzoate settled by the arts of a ward primary, surely such a little thing as a Supreme Court decision cut no figure when he wanted to insult a fellow official. It is odd

though that the Solicitor never learned the difference between drugs and patent medicines. Even now, when the German Government Board charged with the investigation of sodium benzoate has upheld Dr. Wiley, and condemned the Remsen Board, still the little bark of the Solicitor is heard in the land.

Accompanying these letters is the aforementioned pamphlet which is a wierd and wonderful collection of facts twisted to aid the catsup and other industries employing sodium benzoate. This little pamphlet takes up one by one the various preservatives used: formic acid, boric acid, sugar, vinegar, alcohol and salt. As, of course, it is possible to find writers who have condemned even water, as an beverage, so one is not surprised to learn that writers have condemned salt in epilepsy, in constitutional (?) eczema, and of course in nephritis with oedema. Why, one John Knot of Ireland says "salt has proved a lethal agent". As all of us haven't eczema, heart disease, or epilepsy, it follows that there must be a large percentage of us who wouldn't be hurt by salt in our diet in the moderate quantities we use it. That it is necessary for life can be proven by any one; even the wild animals are fond of it. But when we come to boric acid in the pamphlet, the author throws off all disguise. He says *"we* wrote to physicians to ask their opinions", etc., in reference to boric acid and its compounds. Admitting that boric acid would preserve meats longer than salt, is not this the crux of the whole matter, that we want a preservative that will not preserve indefinitely, that the food value disappears after a certain, not too long a time, that boric acid is not a natural preservative in the sense that sugar, salt, etc., are, but is practically an embalming process and as such is utterly distasteful to our stomachs, besides being dangerous, as Dr. Wiley in his classic experiments, has shown? This showing of truths and bending them to fit every case shows us what a publicist is. The ladies who are members of the demimonde are publicists in the same sense, though while they only prostitute their bodies, a scientific man who twists facts that wholesale poisoning may continue is, well—a publicist too.

S. Myers.

The item of interest to medical men in Mississippi that is of the greatest moment at present is the meeting of the Southern Medical Association that will be held at Hattiesburg Nov. 14th. to 16th. It will undoubtedly be the best thing of the sort ever held in Mississippi for, while there is no discount on our state meetings, the Southern Medical is purely scientific in

its aims and draws the best men from a far larger territory than we can. It is undoubtedly the association, outside of his own state, that a southerner ought to support and attend, and we venture the assertion that no man who has attended its meetings and compared them with those of the A. M. A. will contest the statement that he received more from the Southern than from the larger association. A. M. A. meetings are always overcrowded so that the individual member feels a bit lost, and at the Southern he is among his own people and takes more interest and derives more benefit—and that is the reason for his

We are informed by the official journal of the Association, the *Southern Medical Journal,* that there will be no difficulty about railroad rates and hotel accommodations. Hattiesburg is a live little city, too, and well worth seeing. We all know, and like, the Hattiesburg doctors and can depend on them to do the thing up brown.
going.

We urge all who are not members to take advantage of Dr. Jones' invitation which is given in the following circular letter, which we reproduce because we have learned from hard experience that it is difficult to get a doctor to read his mail.

BROOKHAVEN, MISS., Oct. 14, 1911.

Dear Doctor:—

Are you a member of the Southern Medical Association? If not, wouldn't you like to be? It is an organization made up of the leading physicians of the South, dealing largely with conditions peculiar to the South, not so big that the least of us need feel "lost" (as one does in the meetings of the A. M. A.), yet big enough for the biggest men in the profession, many of whom are in the organization. The meetings are always in reach—this year at Hattiesburg—and conducted by men we all know personally, or ought to know.

Membership in the Association carries a subscription to the *Southern Medical Journal,* one of the best journals published, worth many times the price of membership ($3.00). Send your name to Dr. Seale Harris, Secretary S. M. A., or let me do it. You can pay your dues later. What I want is to get more of our Mississippi doctors interested.

The next meeting will be at Hattiesburg, November 14-16, and will be the biggest thing in that line Mississippi has ever had. Make your arrangements to go.

Yours truly,
D. W. JONES,
Councilor for Mississippi.

Society Proceedings.

TRI-COUNTY (COPIAH-LINCOLN-PIKE) MEDICAL SOCIETY met at Brookhaven Oct. 3rd., in the city hall, with the following members present: Arrington, Butler, Boyd, Dampeer, Flowers, Higdon, Jones, Johnson, Little, D. W. Magee, T. K. Magee, McLeod, McRee, Rowan and Wilson. Dr. S. G. Wilson, a former member, just returned from a season of study in Europe, was cordially welcomed and took part in the discussions. Papers were read as follows: Dr. Dampeer on Ante-partum Hemorrhages; Dr. D. W. Magee on Post-partum Hemorrhages; Dr. Rowan on Resuscitation of the Still-born. These subjects were discussed generally by those present as were also the kindred subjects under general division of obstetrics. Upon invitation, Dr. Wilson then gave us an interesting talk about the clinics of Vienna. The doctor, a former Brookhaven confrere, is now located at New Orleans. Brookhaven was selected as the next place of meeting, December 5th., at which time the annual banquet will be held. D. W. JONES.

Mississippi State Medical Association.

New members in the county societies:

G. T. Warren, Natchez, Adams County Society.

Marcus Beekman, Natchez, Adams County Society.

T. H. Wall, Natchez R. F. D. No. 1, Adams County Society. Dr. Wall was until recently a resident of Fort Adams, Wilkinson County.

W. E. Denman, Phillip, Leflore County Society.

F. E. Barr, Sidon, Leflore County Society.

J. L. McLean, Greenwood, Leflore County Society.

John H. Walton, Sardis, Panola County Society.

J. S. Eason, Coldwater, Tate County Society.

G. J. Bowden, Coldwater R. F. D., Tate County Society.

Book Reviews.

HIERONYMUS FRACASTOR'S SYPHILIS, FROM THE ORIGINAL LATIN. A Translation in prose of Fracastor's immortal poem. Printed on hand-made Imported paper; Library Binding. Crown Octavo. The Philmar Company, Medical Publishers, Fidelity Building, St. Louis, Mo. Price $2.00.

The intention in geting out this translation is no doubt good, but what's the use? Only one who studies the literary side would care to read the poem and such an one would in the vast majority of cases be able, and prefer, to read it in the original. HOWARD.

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MISSISSIPPI MEDICAL MONTHLY

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*CANCRUM ORIS, WITH REPORT OF A CASE FOLLOWING TYPHOID FEVER.

J. R. LOCKHART M.D.,

SHERARD.

Though this subject may seem trite to many of you, I have selected it in order that I may relate to you an error I made, hoping thereby to save some one of you, inexperienced in the disease, its treachery and its insidiousness, from erring as I did.

Cancrum oris, or gangrenous stomatitis, is a rapidly spreading gangrene affecting the cheek and gums. Though I shall deal with it as a diseased condition of the mouth, the same process may affect other parts of the body, as the female genitals; also Holt reports a case involving the nose and external auditory meatus.

Fortunately it is of rare occurrence; is usually asymmetric and ends fatally in most cases. Pulmonary gangrene may occur as a complication due to the inhalation of gangrenous particles. More commonly, however, as a complication is bronchopneumonia following the aspiration of gangrenous materials.

The female sex is more liable to this disease than is the male. Among other predisposing factors may be mentioned low, moist climates, over-crowding, filth and unsanitary conditions.

It is especially to be guarded against in measles, scarlet fever, typhoid fever and any diseased condition which lowers the vitality to the minimum.

The bacteriology of the disease has always been in doubt. Rosenbery last year made a bacteriological study of seven cases, one following typhoid fever and six following measles, and found an abundance of the spirillum and the fusiform bacillus of Vincent. Next in frequency were the diphtheria-like organisms, staphylococci, streptococci and, in one or two cases, pneumococci. His deductions from this study of the disease is that it is due to a number of bacteria, chief among which are the symbiotic organisms of Vincent. His reasons for this conclusion are that the first evidence is a membranous or ulcer-

*Read before the Clarksdale and Six Counties Medical Society.

ative process, and in this stage the fusiform bacillus and spirillum of Vincent are present in large numbers; later in the process of gangrene other organisms such as the diphtheria-like organisms, streptococci, etc., appear and from their invasion toxemia develops and the disease proceeds to a fatal termination.

Our attention may first be directed to the mouth by the patient complaining of a pain described as a toothache. On investigation we usually find a dark, ragged, sloughing ulcer near the corner of the mouth. It spreads insidiously for some two or three days before we note any change in the substance of the cheek. Then a hard and sensitive nodule may be felt, over which a brawny induration of the skin is noted, followed by edema and a deeply livid gangrenous spot, which becomes rapidly bullous and leaves a black eschar.. Perforation of the cheek occurs usually in from three to seven days. The breath is one of our surest symptoms, possessing a fetor which is almost intolerable, and which when once noted will never be forgotten. At first the symptoms may be very slight and its onset very insidious, but with the formation of the eschar they become rapidly severe and assume a typhoid type. The temperature usually runs high, ranging about 104° F.

The disease rarely lasts longer than two weeks, terminating by death in from eighty to ninety per cent. of the cases, according to Bogel.

The treatment is divided into prophylaxis and a treatment of the condition after development. Under the first I would advise, in all protracted cases of fever in which the patient's vitality is taxed to its utmost, that we inspect carefully the mouth at every visit and maintain as perfect asepsis as is possible, using our most potent germicides, one of the best being the peroxide of hydrogen. Since the mortality rate is so high and our measures of combating the disease so untrustworthy, we readily recognize that our sheet-anchor is in preventing the developing of the disease. In every case of fever strict watch should be kept on the mouth. Inspect it carefully at every visit and look out for any evidence of the disease.

When the condition has developed we are left to adopt one of several lines of treatment. Gates and Kings in 1889 advised that all sloughing masses be cut away and the ulcerated surface swabbed with a one to five hundred bichloride solution, after which a one to one thousand solution of the same drug be kept constantly applied. They report three cases which recovered with this treatment and warned against the dangers of poisoning from the drug. Murray treated seven cases the

same year in the Liverpool Infirmary for children by excising the diseased tissues as far as possible until bleeding occurred and then applying strong nitric acid. He reports four recoveries and states that in two of the cases the disease was very extensive. Of the three which terminated fatally, two died of pneumonia, while a third died of septicemia. He advised absolute cleanliness of the mouth and directed that the first week the patient be fed through a uasal tube.

Of the more recent authorities, Anders recommends that all cases be quarantined until they are found to be of a non-diphtheritic nature. Our efforts should be towards arresting the gangrenous process and bringing about a healthy reaction on the part of the tissues.

Trim away all gangrenous tissues, which will be found to be more extensive than is indicated by the skin. This should be followed by absolute cleanliness of the mouth and the wound. Strong caustic applications applied to the wound facilitate healthy granulations. Some of the best applications for this purpose are nitric acid, nitrate of silver, Vienna paste and the actual cautery, the application of which must be preceded by a local anaesthetic. Such radical measures may not, however, be necessary in all cases, the milder ones yielding to less heroic treatment. The fetor may be overcome largely by applying an antiseptic charcoal poultice, containing boric or salicylic acid.

Our internal treatment should be directed towards sustaining the patient's strength and improving the poor circulation in the parts. Give nutritious food, tonics and stimulants.

Cahall reports a case treated successfully with antistreptococcic serum. Should the diphtheria bacillus be found, antitoxin should be given as early as its presence is discovered.

In conclusion, I wish briefly to report a case following typhoid fever.

Femlae, aged nine, colored. I was called o see the case August 15th. and found her suffering from typhoid fever. Put her on usual typhoid treatment and saw her again on August 22nd. Had heard from her several times in the meantime. Found her doing as well as could have been expected. Didn't see her again until September 10th., when I found fever running low and patient's condition I regarded as fine, except that she was complaining of a toothach. On examination of mouth in a dark room I failed to see the ulcer, so concluded it was an abscessed tooth, as the gum was swollen and tender. Had antiseptic wash, which I had instructed to be used from first of fever, continued and waited for developments, ignorant

of the precarious condition into which my patient was rapidly drifting. I was called again on September 17th. and immediately discovered my mistake. Found a ragged, black eschar, with cheek badly swollen and the area of discoloration as large as a silver dollar. Her condition was extremely grave. The process continued until almost the entire right cheek was involved, involving the lips almost to the median line. Here a line of demarcation formed and the entire cheek dropped out, together with part of the teeth, presenting a most revolting spectacle. Being called away, the case fell into the hands of another physician and died some six or seven days later.

In conclusion, I want to warn the younger members, who are inexperienced in the disease, from erring carelessly regarding any condition of the mouth which offers a gateway for the entrance of disease germs which in most cases prepare our patient for the undertakers.

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*TUBERCULAR PERITONITIS IN CHILDREN WITH SPECIAL REFERENCE TO THE FIBROUS FORM, AND REPORT OF ONE CASE.

J. M. ACKER M.D.,

ABERDEEN.

When I was asked by our president to select a subject and prepare a paper for this meeting, two things became uppermost in my thoughts, first to select a subject that would be of general interest and profit to the profession, and second to prepare a paper that would, in a measure, at least, not fall short of the requirements.

Tubercular peritonitis is, I believe, and justly should be of great importance not only to us as practitioners but to the laity at large. The peritoneum is quite frequently the seat of tubercular inflammation. Of course in the majority of cases the peritoneal infection is only secondary to other tubercular lesions, in the lungs, bronchi, etc., but not infrequently it may be, and is, infected directly from the intestines, mesenteric glands or the pleura. It may appear at first as the most important tubercular focus in the body.

In a small number of cases there is a history of some local exciting cause, as a fall or blow on the abdomen. The disease may follow an exposure or occur as a sequel to one of the exanthemata. Some authors describe various forms of the dis-

*Read before the East Mississippi Four County Medical Society.

ease, and in general their description is based upon the location of the lesion and the changes which the parts undergo, but for practical purposes of diagnosis it is only necessary to recognize three forms of the disease, that which is plastic or the fibrous form, that which goes on to caseation and last, but one most frequently met with, that associated with ascites.

Miliary tuberculosis of the peritineum with ascites usually develops in a child who is in a chronically poor physical condition, a being who is the subject of eczema, glandular enlargement or has a family history of tuberculosis. The whole peritoneum is thickly set with tubercules, both single and in conglomerate masses. They are present in the omentum and mesentary, also upon the surfaces of the intestines and solid viscera. The peritoneum shows all the changes of acute and subacute inflammation and there is a moderate amount of fibrin and a large amount of serum. Sometimes there is preceding chronic diarrhoea or perhaps a condition of alternating diarrhoea and constipation with indefinite abdominal pain which may lead to the suspicion of some intestinal digestive disturbance. With the enlargement of the abdomen there is considerable tension with compression of the sides so that the abdomen is more oval than spherical. There is little fever, if any, a moderate amount of weakness and the enlarged abdomen is the chief feature as a rule. As said by Kerr in his diagnosis of children's diseases, "Any chronic ascites that is associated with even a moderate fever should be considered as tuberculosis until otherwise proved". The absence of cough or the general symptoms of tuberculosis should not be considered of much importance, as tubercular peritonitis may develop very insidiously in children. It will not go amiss to call attention to the fact that the chest is not always the favorite site of tuberculosis, but that the peritoneum and meninges are very susceptible.

In the diagnosis of these cases we are, in a majority of cases, so to speak, "Up against it". If there is no family history of tuberculosis and no signs of tuberculosis of the lungs or any part of the body it proves nothing against the existence of tubercular peritonitis; if any of these are present, it is indicative of tubercular infection of the peritoneum. Vomiting is not always present and pain and tenderness may not be marked. As the disease progresses the diagnosis becomes comparatively easy on account of the unmistakable seriousness of the disease and the usual termination in death from exhaustion. Less frequently, however, the fluid is absorbed and the case becomes one of the fibrous type with a tendency to relapses.

The ulcerative form may succeed either the miliary or

fibrous form, and from the point of chronicity stands midway between the two preceding varieties. Generally it is a little more frequent in children and whereas it may be localized, it is generally scattered. The inflammation is associated with large tuberculous deposits that go on to caseation and softening. There is always an abundant fibrinous exudate, matting the coils of intestine together, thus causing an adherence to the solid viscera and abdominal walls. Clinically these cases show well-marked constitutional symptoms, due partly to the immediate trouble and partly to the general T. B. Fever is always present, usually ranging between 99 and 102° F. There is a rapid emaciation, prostration, anemia, and sweating. Diarrhoea in this form prevails, and the discharge is more or less bloody in character. We find the enlargement also present here, but it is next to impossible to make out any ascites on percussion, simulating the fibrous in that respect. Fluid can be gotten on puncture. Nodular masses can be felt anywhere in the abdomen. In this form there is usually some sign of disease in the lungs and the process is steadily progressive, death taking place in from two to six months.

The fibrous or plastic forms, and the ones of especial interest here, because of a following discriptive case, have been compared to the fibroid forms of pulmonary tuberculosis. The outcome of this inflammatory process is the production of fibrous tissue. There are extensive adhesions between the intestinal coils and between the intestines and abdominal walls. The mass may be compressed against the spine by bands. If there is any ascites it is almost next to impossible to demonstrate it. The abdomen is enlarged and upon palpation it is easy to detect nodules, enlarged glands or matted omentum. Clinically these things have been developing slowly. Fever is slight or may be entirely absent. Vomiting may or may not be present and the bowels may be loose or constipated. The only characteristic sign is the enlarged, knotty appearance of the abdomen, wtih slight pain. The enlargement and accompanying symptoms may all subside and there have been cases of permanent cure; however, in other cases, and in the majority, after the symptoms have been absent for some time, relapses occur bringing on additional symptoms from the mechanical effects of pressure from the adhesions and the patient is carried off. The course as a rule though is slow and irregular, generally lasting from three to twelve months, but with the remissions and exacerbations it may extend over years. In this form, as in the ascitic, a number recover under medicinal treatment; a few of the ascitic forms have been cured by operation.

Never in the world could any good be derived from operation upon the fibrous form.

In the treatment of patients of this kind the means and measures of treatment are the same as those of tuberculosis in other parts of the body. The essentials are rest in bed, a climate mild enough to allow the patient to remain in the open most of the time, and very careful attention to feeding with the purpose of improving the general nutrition. Drugs play little if any value at all. As has been mentioned above, by means of laparotomy many cases have been cured. The ones to be considered are those of the ascitic variety. Operation is positively contra-indicated in all fibrinous forms not attended with much pain, as they sometimes go to spontaneous recovery. In the ulcerative form it is also contra-indicated, but in no case would the fact that there is another T. B. focus be sufficient grounds to hold off from an operation.

Negro girl, aged ten, very much emaciated. About five years ago she gives a history of having been horned by a cow in the left side of the abdomen. Nothing developed at this time except a little soreness and inconvenience that would naturally follow an accident of this kind. About four summers later the mother noticed a swelling of the whole abdomen, while the child experienced pains that were colicky in nature all over the abdominal region. The swelling continued, the abdomen was very painful on pressure and was hard and knotty. The whole abdomen was distended and, as stated by the mother, reached about the size of an average pregnancy. There may have been slight fever but I could get no history of it. The child was treated for worms but none were found, so the history goes. No physician was called at this time and in a week or so the abdomen became normal again as to size and tenderness. The child after her recovery seemed perfectly well in every way and nothing abnormal was noticed until January 25th. of this year. The abdomen again began to swell and this time became distressingly painful on pressure and the colicky pains more frequent and severe. I was called on January 20th. and obtained, in connection with the preceding data, the following history:

There had never been any T. B. in either the mother's or father's family. As to the possibility of it having been inherited from the mother, I am sure it was not. I disregard the statement of the father to a great extent, as to my mind he bears the markings of a T. B. negro. He did give a history of a cough but beyond that I could get nothing else.

The child's abdomen had increased gradually in size until

on the 30th. it was indeed about the size of a normal pregnancy. Upon palpation, I found a great number of irregular hard masses that I am sure were matted intestines and omentum. The liver and stomach were normal but the spleen was greatly enlarged. Upon percussion there was positively no ascites. There were a few cervical glands enlarged and there was a great enlargement of glands in the groins. These last were most painful. At intervals of about eight minutes the child would experience great pain all over the abdomen and during examination her pain was most distressing. I am sure that the enlarged masses in the abdomen were nothing other than matted viscera, and in some places the different coils of the intestines could be plainly felt.

From Jan. 25th. to Jan. 30th. her bowels had not moved and upon my first visit, Jan. 30th., I gave her a soap-suds enema and the result was a little feces with a greater amount of slimy mucus, mixed wtih some blood. Her temperature on this date was normal but I am sure that there was some fever a little later in the afternoon for I got a temperature of 99.1° F. the following day about two hours later than my visit the previous day. As I take it this was undoubtedly a case of T. B. peritonitis of the fibrous form and one in which an operation would certainly be contra-indicated.

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*GALVANISM AS A THERAPEUTIC AGENT: ILLUSTRATED BY A REPORT OF CASES.

W. J. GRADY M.D.,

AMORY.

The subject I have selected for to-day is too broad for a short paper; however, I have decided or selected to say only a few words on the first part and then illustrate the effects by reports of cases. The good or bad effects of a constant or galvanic current depends of course on the reliability of the machine or agent and the ability or knowledge of the operator, with the constant help of the patient, as is the case in the administration of any other therapeutic agent.

First of all is the use of a machine that is reliable, one that will give a constant, regular current, with a good meter for the correct measuring of your dose, with the knowledge of the operator as to which pole is the active one, for the action of the poles are as far apart or opposite in effect as any two

*Read before the East Mississippi Four County Medical Society.

drugs that you can mention. The positive pole is acid in reaction, germicidal, a dehydrator, allays inflammation and relieves pain, while the negative pole is alkaline in reaction, nongermicidal, irritating,, and liquifies tissue. It would at first seem from the foregoing, and the fact that it is popularly supposed that the current always flows from positive to negative, that if we wish to use any medicament it would be applied on the positive pole, but not so, for if we wish to use a solution of potassium iodide for the effects of the iodine, it being electropositive and therefore repelled by the negative and having an affinity for the positive under the old law that "like begets like", we would use it from or on the negative pole; so also if the base of potassium was the one we wished to use, it being electro-negative and repelled by the positive, it would be used from the positive pole For instance, profound anesthesia can be produced by a solution of cocaine from the positive pole even through the skin; or in other words, all bases whether metallic or alkaloidal have an affinity for the negative pole, and are repelled by the positive pole, therefore would be used on that pole, and the acid, or that which takes the place of the acid, has just as strong an affinity for the positive and is repelled by the negative.

With this brief explanation of each pole I will proceed to recite a few cases to you.

Miss K., aged twenty-four, came to me with this history: began to suffer pain with menstruation at the age of thirteen, gradually grew worse with each succeeding period, with practically no treatment until the age of twenty-three. Was treated by a good doctor for one year, getting worse all the time, losing flesh and becoming anemic; flow regular, scanty and very painful; suffering practically all the time; examination made by the doctor and advised removal of the ovaries. At this stage she fell into my hands. Dilatation was advised and attempted and under an anesthetic I found a very small uterus very much anti-flexed, in fact so much so, with bands at internal cervix, that it was with difficulty I succeeded in getting in a very small dilator and was absolutely unable without the use of the knife to use even a goodell, which was declined, therefore, operation was in a measure a failure. However, she passed through the next period all right, with return at the next period of all symptoms but not quite so bad. She was then put on negative galvanism every third day, fifteen milliamperes for ten minutes intrauterine, followed by strong interrupted induced current for twenty minutes. This was continued to the next period, electrode passing more easily at each seance,

period normal but considerable leucorrhea following treatment, continued only twice a week, trying at each sitting to place the uterus in normal position with electrode before turning on current, at which time patient went home, at the end of two months, with the understanding that she was to return if any further trouble. Leucorrhoea continued but not so bad, and at the end of third month slight return of pain. Patient returned and on examination found uterus practically normal in size, very slight displacement, easy introduction of electrode, therefore, changed to positive pole which is sedative and as I was using a copper electrode was doubly antiseptic. After giving six seances of ten minutes each, followed as before by induced current, dismissed patient. She has no further trouble, now one and half years later. Let me say right here in using the negative pole one has to be very careful as to antisepsis, but not necessarily so with the positive pole, but owing to its great power as a dehydrator of tissues, unless in a cavity where it can be covered with lint or chamois it will stick and give no little trouble. In case it does stick reverse poles and it is soon freed, but you undo and take the chances of infection. However, to prevent sticking gently rotate.

The second case was almost exactly the same. Same history and treatment, except the patient was married and I had the pleasure of delivering her of a nine pound girl that is nine days old to-day, both doing nicely.

Case three is Mrs. M., aged twenty-eight. Been married five years; began menstruating at the age of sixteen, very painful from the start. After four or five years began to pass membranes at every second or third period, going through with all the agonies of childbirth, with quite a free flow at such times only. Periods very irregular, more or less painful all the time, profuse leucorrhea; was operated on by two good men who did dilatation and curettage, and I have every reason to believe it was properly done, but with return of all symptoms in three months, even more aggravated.

Of course in all these cases the nervous symptoms had begun to cut quite a figure. The first case almost to a point of mania. She came under my care in Sept. 1909, electrode introduced with comparative ease: the positive, a large well wetted pad, over the fundus, current turned on to twenty m.a. maintained for ten minutes, at the same time trying to replace the badly retroverted uterus, followed by a large vaginal electrode posteriorly and to her left as that was the most tender spot, pushing well up and forward, induced current interrupted turned on as much as could be comfortably borne for twenty

minutes, continued every third day to twice a week for two months, intermission of three months and treated same way for three months more except substituting positive galvanism interrupted for vaginal electrode in place of faradism. To the present time patient has no more pain, has passed no more membrane, has gained twenty or more pounds but has not as yet become pregnant.

*VARICOSE VEINS OF THE LEG COMPLICATED BY ULCER.

WM. I. COLEMAN M.D.,

ABERDEEN.

This is a condition which I regard as one of especial interest.

From our studies of the subject we will recall that varicose veins of the lower extremity are quite common and that it is almost always the long saphenous veins which are involved. In varicosity there is first an enlargement of the vein owing to loss of elasticity permitting a damming back of the circulation resulting in passive hyperemia of the limb due to enlargement of the veins, and consequent impairment of the circulation. Owing to the enlargement of the veins the valves do not fit closely enough to support the column of blood and there results a stagnation or accumulation of blood causing further enlargement. This is easily demonstrated in the case to be described. If you place your finger, for instance, on the long saphenous vein when it is enlarged you will find that the vein below does not become larger, showing that the blood from behind this point only partially fills the vein; then if you remove your finger you will see that the descending column of blood will cause much greater enlargement of the vein, showing that the varicosity is largely due to the weight of the column of blood. In this case the deeper veins were also enlarged causing a general varicosity. There is marked oedema in addition to the hyperemic condition of the limb, an extravasation of serum into the tissues causing that marble-like oedema totally unlike that seen in other parts of the body. There was also discoloration. This in most cases is said to be due to the destruction of the superficial lymphatic vessels and superficial veins of the skin, even those perhaps immediately beneath the skin, and an extravasation of blood into the cellular tissue takes place. Varicose veins may be the result of many things. Some observers say that heredity plays a part in their production since the

*Read before the East Mississippi Four County Medical Society.

condition is common in certain families, that even the same veins may be involved in several members of the family, looking as if they inherited a lower resisting power of the vessel walls which caused them to undergo certain changes resulting in varicosity. Others say this is questionable. Occupation seems to be a prominent factor in bringing about a varicose condition of the veins of the extremities. We all recognize the fact that varicose veins are more common in women than men, because of pregnancy, abdominal tumors, etc., obstructing the return of the venous blood. As a rule varicose veins do not give the patient a great deal of pain or distress, but occasionally one will see patients with only slight varicosity who will complain of severe pain in the leg, inability to stand on the leg any great length of time and other discomforting symptoms. Patient, a female, aged fifty-two years, occupation housewife, told me that the extensive ulceration seen on the leg, three inches above the external malleolus, made its appearance three years ago, that it was caused by scratching an eczema which existed at that time. A marked varicosity of the veins was present and the sore was a typical varicose ulcer of the leg. She will not attempt to state just how long the varicosity has existed but said "a long time".

I shall not discuss the treatment of this condition from the standpoint of the surgeon, nor take up the radical cure, since many, probably the majority, of patients will not submit to operation for radical cure and, too, there is considerable danger attending the operation, but shall take it up from the standpoint of the general practitioner. The first thing to be done is to support the circulation. This may be done in a number of ways, so the text-books say. As a matter of fact the bandage in some form, or the adhesive strips, is the one most often used and, all things considered, is the most satisfactory. The rubber bandage and the stocking recommended by most writers are hot, do not allow evaporation and there is a tendency to macerate the ulcer and eczematous patches if they exist. The silk stocking and the elastic stocking are both expensive and unsatisfactory. The treatment carried out in my case was as follows: first the entire leg and particularly the ulcer was thereby scrubbed with tincture of green soap and water, dried and to the ulcer was applied a wet dressing of two per cent. solution of acetate of aluminum, covered with oiled silk, this covered with a large piece of cotton and a roller bandage applied from the toes to above the knee; this dressing was changed at the end of twenty-four hours and another applied and this was kept up for three days when the discharge was scanty and the ulcer clean. I then began the use

of camphor in the form of spirits. A small piece of gauze as nearly the size of the ulcer as possible was cut and saturated wtih the camphor; this was applied and over this a dry piece of gauze, then a piece of oiled silk and finally a piece of absorbent cotton; the bandage was again applied as before; every other day this dressing was removed, the ulcer washed with a two per cent. solution of carbolic acid and the dressing reapplied. The ulcer was healed in seven weeks. I do not mean to say that this is a "dead shot" for varicose ulcer, but the results were so gratifying that I thought I would make mention of the case. Of course if the circulation is not supported by a bandage or some other form equally as good there will be a recurrence of the condition, but the patient or some member of the family can apply the bandage after being instructed properly as to the method.

In conclusion, I want to make a plea for these patients, for I can think of nothing worse than being compelled to drag through life with a boggy, heavy limb discharging dirty, foul-smelling secretion, aching and itching as most of them do, breaking down at another point when scratched, and drifting from doctor to doctor where they usually get the zinc oxide or some other ointment, or even worse are introduced to the cautery and escharotics. The patient should be informed in the beginning that it takes time, and lots of it when circumstances are not favorable, that co-operation on the part of the patient is imperative, that it is lack of support to the limb that causes the condition and without that medicine will in all probability not heal the sore, that varicose ulcer is distinctly curable and, last, that you refuse to have anything to do with the case unless they carry out your instructions.

SOME MEDICAL ASPECTS OF UNCINARIASIS.

W. H. ROWAN M.D.,
WIGGINS.

Southern practitioners learned years ago to regard malaria as an underlying factor in many of our common diseases as well as in those of obscure origin, because of its important bearing on the success or failure of the treatment. As the scientific knowledge of uncinariasis increases our physicians will give the same consideration to it, and will find it the "sleeping demon" in thousands of cases with beclouded symptoms. In fact many of our physicians are giving this question

such consideration at the present time that it seems but a short time will elapse before their observations will become common medical knowledge. Hookworm disease is here considered as a contributory factor in these conditions and not a cause *per se.*

In a paper at the last meeting of the Mississippi State Medical Association, a general practitioner from the northern part of the State called attention to the prevalence of hookworm disease in these words: "In my section of the state, I can speak from first-hand knowledge and from what I have seen, I am thoroughly convinced that instead of being a medical curiosity, the hookworm is producing more death, directly and indirectly, and is causing more poverty and wretchedness and inefficiency than any other malign influence in operation there to-day."

We have physicians in our state who are considering this infection so important in its bearings on other disorders, that they have been led into making extravagant claims of discovery ---too extravagent in most instances, because they empiracally place it as a cause rather than a factor. Yet, I must confess that from time to time I have gathered from my medical friends some of the ideas embodied in this paper: certainly on their observations, as well as my own, have I depended for the correctness of these conclusions.

It is becoming well known that hookworm disease is more often a factor in the anemic conditions so prevalent in the sandy districts of the South. Anemia in turn makes a definite paved way for the easy ingress of certain diseases of vast importance to the economic and social problems confronting us, and which are, from day to day, taking their unjust toll of human life.

Briefly we will consider this infection in the following diseases and conditions:

First, delayed puberty. All authors say that the southern child develops into manhood or womanhood at a very early age; theoretically this is correct. In my own country, which borders on the Gulf, the children reared near the coast will show early maturity; they are free from hookworm infection, but immediately you go to the interior of that same county, you will find that this theory does not apply, nor does it apply to the other sandy districts with which I am familiar.

Girls and boys with hookworm infection are retarded in their development without limitation. I know women thirty years of age who have practically never menstruated, and who otherwise have shown lack of development, due to the presence

of this parasite. Many have I known to suffer from the various menstrual irregularities such as amennorrhoea, leucorrhoea and vaginitis, together with numerous displacements of the pelvic organs, all due to this same parasite at some time, present or past.

I have seen men, children in size, appearance, mind and action, more than twenty-one years of age, wearing knee thousers through real shame of their lack of development. I have seen and known middle-aged men who have never had a semblance of beard, whose voices are those of childhood, and who resemble women so much in person that they are often spoken of as hermaphrodites, all due to chronic hookworm disease. Just now I recall a minister of this type who, in the face of this drawback, was a man of much power. Whether this was the cause or not, his youth was spent in a hookworm locality, hence we are safe in suspecting the hookworm as the cause. In none of these conditions should the probability of hookworm infection go unchallenged.

Second, puerperal eclampsia is a condition obscure in its origin, yet we know that it is always attended by a profound anemia, and where we have an anemia already established, as would be the case in a hookworm subject, it is practically certain that the eclamptic toxins when thrown into the already anemic blood and finding no resistance there, would create havoc because of the condition already present.

During the past ten years I have practiced in the center of a highly infected hookworm district, where eclampsia is so common as to be noticeable even to the laity who have lived in other sections. During this term of practice I have had more than twenty cases of this character, and when I look back over this series I see before me one long line of hookworm sufferers, mostly young women, all of whom either lived in the country at the time or who had recently moved to town from the country. This occurrence of eclampsia in the country districts among the women who are known to be hookworm subjects, and the absence of eclampsia in the town women who are known to be free from hookworm infection, has convinced me that hookworm infection is a contributive factor in many of these cases.

Since I have been in this work I have seen two of these cases and in both instances found the women microscopically positive. On month ago I saw such a case, and two women present, who were positive subjects, gave histories of convulsions at the birth of their last children.

Third, rheumatism, also obscure in its origin, is a disease

about which we are often changing our views. Without offering scientific evidence, I wish to mention four cases: the first a boy who was brought to my attention by his physician, who stated that he had been a rheumatic sufferer for more than a year, walking very little of the time. On examination he gave evidence of hookworm infection, thymol was administered, which was followed by immediate recovery. In the dispensary work in Harrison County, Miss., I found two boys and a woman who were rheumatic, all of whom recovered promptly after taking hookworm treatment. One of the boys had been walking on tiptoe to protect his knee.

Fourth, tuberculosis is certainly very common among hookworm sufferers and the downward course in these individuals is rapid. In one instance, two physicians pronounced a case of uncinariasis, tubercular: another physician administered thymol and the patient is a strong man to-day.

Recently I heard of a young woman who was supposed to have died of tuberculosis and "dropsy"; on further inquiry I found that for several days prior to her death she begged for dirt to eat. To me this tells its own sad story!

In another instance two young physicians decided that a similar case was suffering from uncinariasis and suggested treatmen; an older physician, who discounts the hookworm theory, prevented the treatment and, in the opinion of the younger men, took from the girl her only chance of recovery.

Some enthusiasts have attempted to show that pellagra is a manifestation of uncinariasis. I think that I can say positively that such is not the case. I have made eleven microscopical examinations for pellagrous patients and only four of these showed infection; some on account of previous residence and habit precluding the suggestion. But this I will say: the young who have the mixed infection show remarkable power to recover from the pellagra when the hookworm anemia is removed.

There are other conditions in which we can suspect the hookworm as being a silent partner. Time prevents going into them fully, so I will mention them collectively. These are: permanent discoloration of skin, chronic leg ulcer, which is very common, eye strain, bad teeth, indigestion and intestinal disorders. Then we have the various nervous conditions, including some of the central system.

I am sure I am in the bounds of conservatism in these statements. I have lived among, and practiced for, the people who are sufferers from this disease and I unhesitatingly say that the physician who overlooks the possibility of hookworm

infection in his obscure cases is careless. The one who does not consider the disease in its graver aspects, with our present knowledge ofthe subject, has missed the means of making radical cures in otherwise hopeless cases; and at the same time has missed the opportunity of adding his mite to the uplifting of a Southland of naturally great people.

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*DIAGNOSIS AND TREATMENT OF LOBAR PNEUMONIA

S. C. COWAN M.D.,

SABINO.

In the diagnosis I only want to take up the physical signs of the three different stages and treatment of a simple uncomplicated case. In the first stage, or stage of engorgement, the signs may not be very definite, and sometimes the disease passes so rapidly into the next stage that we do not get them at all. The patient usually lies on the afflicted side and there is deficient movement on that side, due to pain.

The facial expression is noticeable. There is a bright red blush over the malar bone of the afflicted side, an anxious expression and the eyes are very bright. There is increased respiration and dry ineffectual cough which the patient tries to smother.

Palpation reveals a dry, hot skin and increased fremitus.

Percussion shows a slightly impaired resonance over the lobe involved which shades into dullness at the beginning of the second stage. In the latter part of the first stage typical creptitant rales are heard which occur only at the end of deep inspiration. The heart sounds are full and noisy over the afflicted part.

In the second stage we find the patient still lying on the afflicted side and note a darker red spot over the malar bone. Respiration is very much increased, the alae of the nose playing rapidly. Herpes is usually noted around the mouth and nose. There is diminished expansion on the side involved. The skin is still dry and hot, the pulse full and fremtus is still more increased.

There is dullness over the lobe, with slight hyper-resonance over the sound lung. There are no rales at all in this stage, but marked tubular breathing. Heart and voice sounds are very

* Read before the Clarksdale and Six Counties Medical Society.

much increased and there is a distinct transmission of articulated sounds.

In the third, or stage of gray hepatization or resolution, there is a gradual return of normal breathing and normal expression. The patient is pale and anemic and sometimes intensely jaundiced and still has increased fremitus, which gradually disappear as resolution advances. There is gradual return to normal resonance but tubular breathing continues and there is a return of the rales which are first moist and then mucous and bubbling.

Put the patient to bed in a well ventilated, well lighted room with as little furnishing as possible and exclude company. The diet should be bland and light and as nourishing as possible: broths, soups, milk and water at regular intervals, and plenty of it. Give a free calomel purge, followed in four hours by a saline. This should be repeated every two or three days. Quinine in full doses for twenty-four to thirty-six hours to eliminate malaria, which is usually present. Then treat symptoms as they arise.

Temperature, unless it goes over 103¼ or 104° F. and causes nervous symptoms, I don't think requires anything. When it does an ice cap is good or three to five grains acetanilid with quinine acts very nicely. Pain sometimes is relieved by a flannel cloth saturated with turpentine over the affected part, counter-irritation as dry cup, and if the disease is very severe a fly blister, which I don't think needs to be very large.

For cough we may use a combination of turpentine emulsion made with castor oil and ammonium chloride in small doses of heroin or syrup of tolu in elixir of lactated pepsin.

There is not much need of stimulants until the approaching crisis, then strychnine or spartine either by mouth or hypodermatically, egg-nogs, alcohol sponges, etc., may be used. When resolution begins push ammonia salts and if resolution is tardy give alteratives, as iodides. Build up system with hypophosphites, etc.

Owing to the removal of Dr. H. N. Page Jr., University, the chairmanship of the section on Physiology, Pathology and Bacteriology is vacated and President Williams has appointed Dr. C. C. Hightower of Hattiesburg to the office.

The committees on Public Policy and Legislation and on Medical Education will hold a joint meeting at the Board of Health Office, Jackson, Saturday, December 9th. at 10 A. M.

MISSISSIPPI MEDICAL MONTHLY.

E. F. HOWARD B.S., M.D., Editor and Publisher.

S. MYERS M.D., Business Manager.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

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As the time for a new deal in legislation approaches, we should begin to "sit up and take notice" a little more energetically. It is true that quite a number of the legislators have been convinced of the wisdom of granting the requests the Association will make at the next session, but as matters now stand the vote on them will hardly be unanimous, which means that there are still some who need convincing. Let's go after them.

It is a well-known fact that a high degree of enthusiasm on the part of one man will often carry along others who would otherwise rank with the opposition. Some who will vote for us won't show this enthusiasm because they are not sufficiently impressed with the great necessity of passing our bills and the benefits that will accrue to the state from such action. Let's go after them.

The committee is working hard but can't do it all. We could make the vote unanimous if we could but reach every member of the legislature. Think what a great thing it would be for the state if we could secure every vote. Let's go after them.

The meeting of the Southern Medical Association at Hattiesburg set a new record for that organization. The largest attendance on record, a program filled to repletion with papers of the highest order and a series of entertainments that could have been provided only by such men as the Hattiesburg physicians, occupied every moment of the three days of the session and then called for further time. In fact there was so much doing that many of the members were strongly of the opinion that in future the program must be limited or the sections

further divided. The masterly presidential address of Dr. Isadore Dyer contained suggestions along these lines that are well worthy of adoption and should this be done the members of the Southern Medical Association will have provided for them such an annual treat that no one of them who even pretends to interest in the forward movement of his profession will be willing to absent himself, and the day will soon come when failure to acquire membership in the Southern Medical Association will be tacit admission of professional inertia.

Society Proceedings.

Tate County Medical Society met in regular session in Senatobia at 6 P. M. Nov. 1st., Dr. J. J. Wilson, president, in the chair, Dr. R. A. Reynolds secretary pro tem. Dr. J. S. Eason, Coldwater, read a paper on the treatment of typhoid fever which was well received and discussed by the entire membership present. Dr. A. J. Kisner's paper was postponed to the next meeting so that the doctor might be present to himself read it. Dr. J. A. Vaughan, a visitor from Memphis, was called upon to make a short talk on typhoid, which he did, calling attention to the free internal administration of water. Election was held with the following results: Dr. R. D. Williams, president; Dr. W. D. Smith, vice-president; Dr. W. D. Smith, secretary-treasurer, re-elected; Dr. D. C. LaVerne, censor for unexpired term of Dr. Tennant, who has moved away; Dr. J. W. Crawford, censor, three years. After some discussion the dues for 1912 were fixed at six dollars, same to go as far as it would toward all expenses of suppers, etc., but not to include the state dues. The secretary was instructed to collect this before the next meeting, which will be in January. The society adjourned to the French Hotel where the proprietor did himself proud in the repast which he served to the society. This meeting closed the year for this society and it has proven a most successful one, due to the energetic work of the president and some of his friends. The society hopes to make 1912 a more successful year, to increase the already good membership and, if possible, to make the meetings more interesting.

W. D. Smith.

Book Reviews.

THE PARASITIC AMŒBÆ OF MAN. By Charles F. Craig M.D., Captain, Medical Corps, United States Army. J. B. Lippincott Co., Philadelphia. Price $2.50.

As the Panama Canal has already brought us into closer contact with tropical countries than heretofore and its completion will make this union even more intimate, we have to consider more and more the diseases of the tropics. Hence this, the first monograph that has appeared in English on this subject, is timely and should receive a cordial welcome. Dr. Craig, by no means unknown as an investigator in tropical medicine and a contributor to its literature, bases his book on twelve years' acquaintance with amoebic infections, comprising several hundred clinical cases and autopsies. The history, morphology, biology, classification, nomenclature, laboratory tecnic, and cultivation of the parasitic amoebae are fully considered and then the different varieties are taken up in detail and discussed at length. The book is what might have been expected of such a man as the author and should find a place in the library of every physician practicing in the south or in any seaport in the country.

HOWARD.

THE TREATMENT OF FRACTURES. With Notes Upon A Few Common Dislocations. By Charles Locke Scudder. Seventh Edition, Thoroughly Revised and Enlarged. With 990 Illustrations. W. B. Saunders Company, Philadelphia and London, 1911. Price $6.00.

"Best text-book upon fractures in the English language" is the universal opinion of this work of Scudder's and it is difficult to see how it could be improved upon. We note the addition of many new illustrations which aid greatly in solving the difficulties that arise in the treatment of traumatic lesions. Particularly good are the x-ray photographs which with the accompanying explanations ought to be of great value in studying x-ray pictures in the average surgeon's hand. We note the introduction of much new matter concerning fractures of the skull, old fractures of nasal bones, fractures of the spine, excision of the shoulder joint, damage to the musculo-spiral nerve, fractures of the neck of the femur, old fractures of the lower end of the tibia; injuries of the lower tibial epiphysis. This is the most up-to-date surgical work and a necessity to every man dealing with injuries.

MYERS.

INTERNATIONAL CLINICS. A Quarterly Of Illustrated Clinical Lectures And Especially Prepared Original Articles. J. B. Lippincott Co., Philadelphia. Price $2.00.

Watson of Philadelphia discusses "Some Uses For Some Old Drugs" that are being forgotten, apparently, by modern therapeutists; there are two good articles on therapy in circulatory disorders; medicine, pediatrics, neurology, surgery, otology and obstetrics are represented in good articles; Zentmayer gives some hints on refraction for the benefit of the general practitioner; and there are excellent articles on the successful practice of medicine and economic conditions affecting physicians, subjects too generally ignored for the good of the profession. HOWARD.

THE PRACTICAL MEDICINE SERIES. Series 1911. Vol. VII. Pediatrics, edited by I. A. Abt M.D., of the Northwestern University Medical School, and Orthopedic Surgery, edited by John Ridlon A.M., M.D., of Rush Medical College. The Year Book Publishers, 180 N. Dearborn St., Chicago. Price $1.25.

An excellent resume of the literature of pediatrics and orthopedic surgery for the past year. HOWARD.

A TEXT-BOOK OF THE PRACTICE OF MEDICINE. By James M. Anders. Illustrated. Tenth Edition, Thoroughly Revised. W. B. Saunders Company, Philadelphia and London, 1911. Pp. 1,328. Price $5.50.

A text which in the short space of twelve years has undergone the test of ten editions, besides numerous reprintings, may indeed be described as a success, and this, Dr. Anders' textbook on practice, unqualifiedly is. The large experience of Dr. Anders in teaching has made it possible for him to pick out the subject points to impress the student's mind with in the diagnosis and treatment of the different diseases discussed. The Northern writer as a rule ought to leave malaria alone; we observe in this otherwise perfect text-book the suggestion that in malarial regions "caps to which wire netting is attached should be worn out of doors". (p. 357.) Fancy us trotting around with veils of sixteen-mesh wire gauze over our faces! But we must also not forget that malaria looms up something terrible to the northern mind, just as epidemic polio-myelitis does to us. We cordially recommend this practice to anyone desiring an accurate reference book. MYERS.

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MISSISSIPPI MEDICAL MONTHLY

VOL. XVI. JANUARY 1912. NO. 9

*ETIOLOGY AND PRACTICAL TREATMENT OF ECLAMPSIA.

J. L. ANDREWS M.D.,

MEMPHIS, TENN.

We have come to realize that we must look further than to systematic examination of the urine for a danger signal in the avoidance of eclampsia in the pregnant woman. The pulse—is it hard or soft, feeble or bounding, wiry or full? Is the tension natural or otherwise? The nervous system—is it equable or disturbed with the slightest causes? The brain—are its functions normal, or is dystocia expressed by disturbed vision, frontal headache, etc.? The various reflexes—are they normal? The abdominal viscera—are they normal upon physical examination? The blood—does its examination reveal pathological conditions? Is the excretion of urine normal?

With all of our learned theories we have come to know that eclampsia is strictly a vice of elimination; that there are certain toxins which must be prepared for elimination by the liver, and excretion by the kidneys; that eclampsia may be caused either by the failure of the liver to prepare for elimination, or the failure of the kidney to eliminate after preparation. But, as to the exact nature of the toxins, their mode of preparation for elimination by the liver, or the actual elimination by the kidney, we have absolutely no accurate knowledge whatever. Of theories, however, there are no end.

A few—and we shall deal only with those so recent as not to be found in books.

In an extensive monograph, Dienst analyzes critically the etiology and pathology of eclampsia. His investigations covered the concentration of the blood, the white blood-cells of the blood and the ratios between serum albumin, serum globulin and fibrinogen. His study of the white blood-cell reveals the fact that a moderate leucocytosis exists during pregnancy; a marked one during labor, and a considerable one in the early puerperism. In eclampsia, however, a sharp rise in the total

*Read before the Clarksdale and Six Counties Medical Society.

leucocytes, as well as in the polymorphonuclears is to be expected.

In four eclamptics examined he found the total albumin per cent. of the blood plasma slightly lower than in normal pregnancy. The fibrinogen showed a marked increase. This fibrinogen cannot come from the foetal blood, and Dienst declares that it must come from the material surface of the placenta. He, therefore, offers the conclusion that eclampsia is due to an over-accumulation of fibrinogen and fibrin ferment in the blood.

Dienst considers that the placenta is the seat of greatest destruction to the leucocytes and it is in consequence in the retroplacental blood that the greatest percentage of fibrinogen is to be found. The fibrinogen and fibrin ferment are considered to have a pernicious effect upon the endothelial lining of the small blood-vessels, throughout the body, but especially the liver, kidneys and brain. As soon as the body is unable to cope with this increase of fibrinogen and fibrin ferment, insufficiency takes place, particularly on the part of the liver and kidneys; a vicous circle is set up, and as a result we find dropsy, albuminuria, eclampsia with or without convulsions developing.

In the treatment of the condition Dienst suggests a restriction in the salt-intake of the body, as well as in albuminous substance. He believes in the use of morphine. Finally, he advises the early rapid emptying of the uterus, both of child and placenta—for the latter he believes to be a storehouse of fibrin ferment and should be delivered therefore at once after the birth of the child, before any additional supply may be thrown into the general system.

Welch reports the findings in fourteen cases of eclampsia, and four cases of toxemia of pregnancy as follows:

I. The liver lesions in eclampsia are not uniform. Pregnant or postpartum women, dying from convulsions, may have hemorrhages, central necrosis, general autolysis, or cloudy swelling in the liver.

II. The liver lesions in toxemia of pregnancy are not uniform. They may be either haemorrhagic or central necroses, both of which are found in eclampsia.

III. The haemorrhagic lesions are produced by liver placental cell emboli, thrombi formed from blood plates and fused red blood cells and by a solution of vascular endothelium. Heightened blood pressure increases the extent of the haemorrhages.

IV. The agent producing the haemolysis and general cell destruction is probably an enzyme.

But, in the state of our present knowledge, we cannot insist too strongly that these are theories only, and we must hark back to the idea that eclampsia means faulty elimination; further that women with active livers, active skins and a free satisfactory action of the intestinal tract, and a competent kidney function do not have eclampsia. Still further must we realize that patients frequently make spontaneous recoveries, and that physicians should be most careful lest their efforts hinder rather than help patients to recover.

The crying need of the whole subject is that physicians make careful routine examinations of their pregnant patients. If obstetricians attended to their patients as they should eclampsia would be wiped out. Obstetrics is the most neglected field of medicine. The pay of the obstetrician is less, frequently, than that of the day before. If he makes from twelve to twenty urinalyses, several ante-partum visits, is engaged with his patient an average of eight to twelve hours, and makes a number of post-partum calls, the simplest calculation will show that he is working absolutely for nothing. If the obstetrician never sees his patient until he is called to deliver her, and then not afterwards, he is dear at any price—even the pitiful pittance which he receives. But if he has her under observation from the beginning of pregnancy to its close, makes frequent and thorough examinations, he is entitled to a fee several times as large as he now receives. We must give our patients, themselves, careful instructions as to danger signals, persistent headache, difficult vision, return of nausea, diarrhoea, marked decrease in amount of urine excreted and oedema anywhere about the body.

An admirable summary of the prophylactic management has been given as follows:

1. The first step in the prophylactic treatment of puerperal eclampsia is so to manage our cases of pregnancy as to reduce to the smallest number possible the cases of toxemia.

2. When our watchfulness has discovered that in spite of such management we have toxemia, treat the case vigorously at the beginning, going to an extreme with it, and only terminating the treatment as the results of it justify.

3. When labor begins examine the urine as soon as possible after reaching the case; examine again during and after labor. Begin giving chloral with the onset of labor, and continue until danger is past. If the symptoms are becoming more pronounced as labor advances, terminate it.

4. If, at the close of labor, symptoms are present, either of impending eclampsia, or even of a remote chance of eclamp-

sia, treat the case as if the convulsions had already occurred, and in this way prevent the actual occurrence of many that will come if nothing is done.

In the face of actual eclampsia the following indications are in the main clear and not under dispute:

1. Control convulsions.
2. Prevent return: (1) by arousing all emunctories, using cathartics, diuretics, diaphoretics, etc.; (2) lower blood pressure with veratrum viride and blood letting.
3. Introduction of normal saline solution.
4. The use of lumbar puncture.

But the main argument is as to our attitude toward the pregnant uterus. I am constantly impressed with the fact that obstetricians array themselves at one extreme or the other of this question. First, those who regard the uterus as a *noli me tangere*, under all circumstances in eclampsia; second, those who believe that the uterus should be emptied as speedily as possible. As to whether the uterus should or should not be emptied I am governed both in teaching and practice by certain circumstances: the degree of severity and frequency of convulsions, the condition of patient between convulsions, the extent to which pregnancy has advanced, the condition of the cervix and cervical canal—the cervix—whether hard or soft, rigid or dilatable, or already dilated. The cervical canal, whether effaced or not, and to what extent nature has attempted to expel the foetus.

If the convulsions are light and infrequent, with consciousness between; if there are no labor pains, no cervical dilatation or softening, no cervical canal effacement, the following plan of treatment is clearly indicated. Control convulsions with chloroform, use hot packs, and use intravenous transfusion, or use veratrum viride. And, most important of all, pack uterus as full of sterile bougies as you can get it, and pack the cervix and vagina full of gauze. This is the well-known Krause method of the induction of labor. Do not use ergot or other ocytocics. The net results of this treatment will be the elimination of toxins, with the induction of labor, cervical dilatation, etc., without shock to patient. On the other hand if convulsions are severe, and intervening coma complete; if cervix is soft, dilated and dilatable, the indications are again clear. Complete dilatation if necessary, by the Harris or Goodell method, do a version or an axis traction forceps operation, and deliver placenta quickly, favoring moderate bleeding from the uterus. Finally, if convulsions are terrific, pulse running riot, respiration stertorous and coma complete, with hard, rigid os,

no effacement of cervical canal; unsatisfactory and slow response to treatment. In the face of these conditions what shall we do with the uterus? Three or four plans are available: let it alone, practice rapid manual or instrumental dilatation with high forceps or version, do vaginal hysterectomy or vaginal Caesarean section, or do abdominal Caesarean section.

Many there are, indeed, who are absolutely in favor of leaving the uterus alone and treating the convulsions. But the contribution of a dead foetus to the general systemic intoxication is large, while that of a living foetus is tremendous. We know that the least dangerous of all forms of eclampsia is postpartum, for the reason that the toxic element of the foetus is absent. On the one hand is to be considered the harm the foetus is doing—on the other is to be considered the additional shock entailed upon the mother in its delivery. With a rigid cervix the amount of shock in delivery through the natural passages is tremendously great, with the added disadvantages, as a rule, of severe lacerations of the maternal soft parts. Under the circumstances just enumerated, an abdominal Caesarean section promises best if vaginal and other examinations have been carried out with proper regard for strict asepsis. If this is not true, if the patient has been examined and generally handled in a careless manner, Caesarean Section is absolutely contra-indicated.

If, then, Caesarean section be contra-indicated on account of previous possible infection, the next best thing is to practice the Krause method, while at the same time, attempting to steady the nervous system by the various processes of elimination.

To recapitulate:

Eclampsia is a preventable condition in the vast majority of cases. The obstetrician who makes careful systematic examination of his cases of pregnancy will have few cases of eclampsia.

Prodromes—the pre-eclamptic state—are present in the vast majority of cases. Woe to him who neglects or disregards them.

Regardless of the stage of pregnancy, if severe symptoms of eclampsia develop, conservative measures for inducing labor must be started at once. A physician brought his wife, who had been having convulsions intermittently for a week. Her cervix was as tight as a bone. Her condition was desperate. Any attempt at delivery would have been fatal. If labor had been induced sooner, at the beginning, her life could have been saved. She died in an hour. Post-mortum Caesarean section

failed to save her baby, though it was alive after a week of convulsions.

Veratrum viride is a two-edged sword. If used early with hard, bounding, rapid pulse, its use is a specific. If used late, its cardiac effect may be extremely untoward.

---

*CONSERVATIVE TREATMENT IN CASE OF RUPTURED KIDNEY WITH SUCCESSFUL RECOVERY.

A. W. RHYNE M.D.,

BEULAH.

After being called upon by our worthy secretary for a paper for this evening I decided to give something I think will be of interest to the general country practitioner and will no doubt elicit criticism from the surgeon. I say will no doubt elicit criticsm from the surgeon because at one stage of the game during treatment of the case to be reported my conscience severely criticised and censured me for not calling in a surgeon to make an abdominal exploration.

On the morning of November 31st., last, a lady came into my office for medical advice concerning her little adopted servant boy who had been kicked the previous afternoon by a horse. She said he had suffered intensely all night and had vomited almost incessantly. I learned he had no passage from bowels or bladder since the injury. I told her I apprehended serious trouble internally and it would be best to see and examine him. She told me she would let me know later about seeing him, but sent a runner sooner than later, for he soon was passing very bloody urine.

On examination I found nothing by inspection except considerable bulging in the lumbar region which was very painful on palpation and the pain was referred to the inguinal region. He was nauseated and vomiting and very much depressed.

I gave him a hypodermatic of morphine and atropine to quiet the pain and vomiting, directed a hot water bag placed over the painful region and one-half dram of fluid extract ergot to be given by mouth every three hours. Also instructed the attendants to keep him on his back and not allow anything to enter his mouth except hot water.

I saw him again on the next morning, 22nd., and found all

*Read before the Clarksdale and Six Counties Medical Society.

symptoms improved though the hemorrhage was still bad. Saw him again next morning, 23rd., and found all symptoms so much improved I discontinued my visits and had the case reported to me every day. The bulging or tumor formation was much larger than on the first day and I told them to keep him on his back and strictly on liquid diet. On the 28th. he was carried from one room to another and was seemingly all right. On the 29th. he ventured from his cot and only took a few steps before he caught his side and almost screamed with pain and in less than two hours had a very copious passage from the bladder which was almost pure blood and contained very large clots. I was called at once and found him suffering with intermittent pains, vomiting and very much shocked. Could retain nothing by mouth, so I gave him a hypodermatic of morphine and strychnine. His temperature dropped to 97° F. in a few hours. Hemorrhage was free and contained any number of large clots. I directed ice bags placed entirely around the kidney region, lowered his head and shoulders and gave him morphine and atrophine hypodermatically to keep pain and nausea under control and strychnine to support him as needed.

The next morning, December 1st., his temperature had dropped to 95⅖° F., hemorrhage still bad but scarcely any clots and bulging of side not so large. His temperature fluctuated from 95⅖° to 96° F. from December 1st. to the afternoon of the 31st., when it dropped to 95° F. and he was seemingly almost lifeless, but the hemorrhage was so much better I entertained hope for him and went to work accordingly. I gave him in the pectoral region by hypodermoclysis all the normal saline solution it would take up and he began to improve at once. By the next morning his temperature had gone up to 97° F. and he was much better in every way. The next day the temperature ran up to 101° F. and the abdomen was badly distended, but these symptoms were easily controlled and in a few days were normal.

My treatment after the secondary hemorrhage in a nut shell was this: to pack the entire kidney region in ice, keep him flat of his back with head and shoulders lowered, allow nothing for first three days to enter his mouth except a little hot water, control the pain and nausea by hypodermatics of morphine and atropine and give strychnine sulphate as needed to support him. I also kept the bed heated up with hot water bottles. Simply sustained life with blood pressure at its lowest ebb until the hemorrhage checked and then gave him normal saline solution by hypodermoclysis to raise the pressure and temperature.

I kept him in bed for four weeks after the secondary hem-

orrhage and limited his diet to liquids, principally buttermilk. The tenderness and some bulging in his side continued for three weeks after I got the hemorrhage under control. The boy made a complete recovery and has been working since January first.

Now the question is will I have such success in the next case from similar treatment or should I call in the surgeon with his knife to make an abdominal exploration, or should I have called him in in this case?

---

*A CASE OF PURPURA RHEUMATICA WITH DIPLOCOCCI IN THE LESION.

WM. B. JOHNSON M.D.,

GREENVILLE.

It is yet unproved what micro-organism causes the various symptoms of rheumatism, though there are many good reasons to believe rheumatism is a germ disease.

There has been much confusion of arthritis with acute articular rheumatism and consequently each micro-organism causing an arthritis has been presented as the cause of rheumatism.

It still remains for some one to isolate the germ from a rheumatic lesion grow it in pure culture and with it causes like symptoms and lesions in another organism or hose, and again isolate the germ from this second lesion. Further the germ must be identical with the germ causing rheumatic manifestations, before we can say that rheumatism is casued by specific germ and each of its symptoms is merely a localized manifestation of the disease.

The English scientists, Paine and Poynton, named an organism diplococcus rheumaticus which they found in pleura, peritoneum, pia mater, synovial membrane, nodules, lungs, urine and blood of patients with rheumatism.

They believe, though it is sometimes difficult to demonstrate, that this diplococcus is probably present in all the chief rheumatic lesions.

They describe the germ in culture as small, pale diplococci, many of which appear to be degenerate forms, for many seem swollen, giving a pear-shaped appearance.

Since the germs in the following case are so similar to

* Read before the Washington County Medical Society.

Paine and Poynton's and the culture in each case was so acid, it seems rational to place these findings as contributory evidence to the diplococcic cause of rheumatic lesions.

The patient, a clerk twenty-seven years old, consulted me in March for pain in the shoulders, which was so severe that the hands could not be raised to the head. There was the history of a wet bedroom floor, from rain through a broken window. There was no fever and the pain did not confine him to bed.

Acute articular rheumatism was diagnosed and a five-grain tablet of aspirin was given every two hours for six doses, then at longer intervals.

The pain was less severe after four or five doses and in a few days the case was cured.

Six weeks later I again saw the patient, this time for purple spots on the inner side of the right leg, just above the ankle. These began as small spots, coming one after the other and growing larger from day to day.

There were four of these spots when I first saw him, ranging in size from a quarter of an inch to an inch in diameter. They were firm, elevated areas made up of small vesicles filled with clear serum and were traversed with blood vessels. They did not disappear on pressure.

The spots were associated with no other manifestation except very severe itching, there being no fever or joint symptoms. They appeared slowly, increasing in size and number and were on the increase when treatment was begun.

Sodium salicylate was given in nine-grain doses every four hours. The itching soon became less severe and the spots began to fade. In two days they had lost their red color, and in a week or ten days all traces of the spots had disappeared.

Before treatment was begun and under rigid asepsis, slides and boullion cultures were prepared from the blood and serum of the two spots. The slides were negative.

Day after day passed without noticable cloudiness in the boullion culture and it looked as though they too were negative, but after fourteen days a slight precipitate was noticed which on gentle agitation did not mix with the clear boullion above, but formed threads.

These threads, stained with Loeffler's solution, showed a pure culture of diplococci. There were numerous groups in which one of the two was smaller than its mate, giving a pear-shape to the couple, and in rather a large proportion one of a couple would be biscuit or pear-shaped.

A second tube inoculated from the first gave a similar growth.

A rabbit and a puppy hypodermatically inoculated with the culture gave no reaction.

The finding of the diplococci in a skin lesion closely following articular rheumatism and responding so markedly to antirheumatic treatment led me to report this case.

---

*CRANIAL SURGERY.

J. W. BARKSDALE M.D.,

WINONA.

It is a far cry, comparatively speaking, from the crude cranial surgery of forty or fifty years ago to the present day modern methods of dealing with injuries or diseases affecting the skull or its contents. Truly it may be said with reference to all but recent efforts in this field

"This narrow cell was life's retreat,
This spot was thought's mysterious seat",

and "Thou shalt not" has been written large over all attempts at cranial exploration. The time is not far past when we contented ourselves with ourselves with trephinign in certain injuries, such as fracture, or in attempting to relieve some of the simple conditions affecting the vault or its covering, even sitting down idly in fractures or serious injuries of the base awaiting the inevitable result, which was usually a speedy death. It is true that the advance in this field, as in most other fields of modern surgery, has been largely brought about by aseptic methods, while the laboratory and investigations in comparative anatomy have added not a little to our knowledge of this subject. Nor need we yet believe that we have achieved the acme of surgical desire in remedial measures for those afflicted with cranial injury or suffering from intracranial diseases, for, great as the advance has been, it is probable that we are only standing on the threshold of what the future will develop.

It is not my purpose to enter into an extensive treatment of this subject, which could not be attempted, or but barely touched upon, within the scope of a paper of this sort, but it will probably suffice to mention in a casual manner the variety

* Read before the Clarksdale and Six Counties Medical Society.

of ailments which are amenable to surgical treatment, and give a brief description of the way in which good may be accomplished, even where complete surgical cure is not possible. No attempt will be made to discuss the anatomy or topography of the brain, as this phase of the subject requires perhaps more careful and painstaking study of the gross as well as the histological anatomy than anything else in the entire realm of medicine.

To recite then, briefly, the commoner maladies which will come within our care as surgeons and practitioners of medicine, we will first consider those conditions which are the result of injury and then those due to disease proper. First in order will probably come concussion. This is to be differentiated from contusion, compression and hemorrhage, which can usually be readily done by its evanescence, its freedom from paralytic symptoms, rather quickened pulse and slight loss of consciousness. Concussion supervenes immediately on the reception of an injury and is always the result of traumatism. It is generally held that concussion is accompanied by minute foci of cerebral contusion, so that in certain cases of long continued coma, accompanied perhaps by other evidences of graver trouble, one should suspect actual laceration of the brain tissue, compression or hemorrhage. As an offset to the view that contusion always accompanies concussion, certain cases have resulted fatally without demonstrable pathological change of any sort. Simple, uncomplicated concussion is, as a rule, recovered from in a few hours, or, at most, in a day or so. Should the period of unconsciousness be unduly prolonged, operative interference had best be resorted to, for I agree with most authorities that it is better occasionally to needlessly perform operation than to neglect to do so in certain cases where benefit may accrue.

Compression, as a rule, comes on more slowly, though it may be immediate and urgent. There is complete unconsciousness, generally amounting to absolute coma, slow, full pulse, dilatation of the pupils, sighing respiration, which may be of the Cheyne-Stokes type, followed by a quickening of the pulse with marked rise in the blood pressure, and exaggeration of all symptoms where the compression is of an increasing type, with death as a consequence of respiratory failure, or else, after a few days time, in other cases, the pressure symptoms may subside and rapid convalescence ensue. Compression, the result of long-standing intra-cranial disease, usually presents an entirely different clinical picture from the above, as the brain in a measure adapts itself to its slowly changing environment.

There is also quite a difference in the effect of pressure locally exerted, *e.g.,* a clot, fracture or neoplasm, and one which affects the entire encephalon, as in a great increase of fluid in the subdural space, as in the latter case the brain suffers more or less uniformly with perhaps the greatest damage in the neighborhood of the brain stem, whereas, in local compression, if not too great, the effects are largely local, the brain accommodating the offending substance by a squeezing out of a portion of its blood. It is important to differentiate between concussion and compression, as pure concussion requires no treatment beyond rest in bed, ice caps to the head and mild purgation, while compression may call for the most prompt interference. Hemorrhage is another condition to be considered here, as there will usually be the added symptoms of compression, either local or general, depending on the quantity and situation of the effused blood. Hemorrhage, except in disease of the cranial vessels, such as aneurism or atheroma, is laways the result of injury, is quickly noted and carries with it the characteristic free interval. This "free interval" is explained in the following way: the necessary force required to produce a rupture of any of the intracranial vessels is nearly always sufficient to produce unconsciousness, the result of immediate concussion; then follows a return of consciousness as the effects of the concussion wear off, to be again followed by insensibility. This period of consciousness is what we term the "free interval", and is almost diagnositc of hemorrhage, though it is sometimes absent. During this free interval, careful attention may elicit focal symptoms which will greatly aid us in accurately locating the position of the clot. The size of the effused clot varies with the vessel injured and also with the seat of the lesion. The vessel most frequently involved is the middle meningeal or one of its branches, and the amount varies from a small clot that will cause but little trouble to one covering almost an entire hemisphere. The symptoms following are generally focal as well as constitutional and the focal symptoms offer a good guide to the seat of the trouble. In compression of any degree of severity and in hemorrhage prompt surgical measures should be resorted to; this is especially applicable to any active bleeding, as a quick recognition of the trouble and the securing of the wounded artery with removal of the clot will enable us often to save life where dilatory measures would result in a fatal outcome.

Trephining for compression, or rather doing the sub-temporal decompression in the manner advocated by Harvey Cushing of Baltimore, will in almost every case give relief where

there is simply an increase in the intra-cranila pressure. In doing this, it is important that the membranes be incised where the tension is sub-sural, else the operation will give comparatively negative results. In hemorrhage, the trephine opening must be according to the suspected site of the bleeding point, which, as stated above, will nearly always be found to be one of the branches of the middle meningeal. Should there be difficulty in determining which branch is involved, the main vessel should be sought and ligated. Roughly, the site of election is two fingers' breadth above the zygoma and a thumb's breadth behind the vertical process of the malar bone (Voigt's rule). It is generally unwise as well as unnecessary to drain these cases, for there is no part of the body so apt in taking care of itself as is the cranium, either exteriorly or interiorly. A drain, therefore, where infection does not exist at the time should be guarded against just as much as in abdominal surgery.

Fractures of the vault, I take it, are too familiar to you all to require but scant attention at my hands. Where a depression exists, or in any case where suspicion justifies the thought of fracture, the scalp should be shaved, prepared and a horse-shoe shaped incision made over the supposed site of fracture. The careful surgeon will always make this incision, if possible, so that the base of the flap will include one of the important vessels, thereby insuring its subsequent vitality, which is especially important where an osteo-plastic flap is contemplated. If a fracture is found, elevate the same if needed, or do whatever may be indicated; if there is no bone lesion, no harm has been done and a safeguard has been thrown around the patient which cannot be given him in any other way than by viewing the vault in many cases.

Formerly there was no graver class of injuries than fractures of the base, principally on account of their exceeding liabilty to infection, rather than from an inherent mortality dependent on actual damage done to the brain or its bony covering. While this high mortality still maintains, yet it is not nearly so great as formerly when all cases were treated purely on the expectant plan. To-day, the sub-temporal decompression, with drainage, in the manner indicated above, is the acknowledged only method of treatment. Here ample provision is made to guard against too great increase in the intra-cranial pressure by a rather extensive bone defect coupled with thorough drainage.

It is even suggested, and occasionally practiced, that purulent meningitis should be treated in this manner, and the sug-

gestion is a timely one. I do not hesitate to state that I believe that many lives suffering from this affection, when not too widespread and not tubercular, could be saved by timely intervention. It is simply the old surgical rule of drainage applied to the cranial cavity as it is applied to other portions of the body.

Cranial growths have perhaps offered a more fruitful source for brilliant achievement in this domain of surgery than any other. The successive advances that have been made in the removal of these neoplasms, or in the palliation of their effects, have been accomplished by careful study and laborious research, both clinically and experimentally, by such able investigators as Starr, Horsley, Cushing and a host of others. Though far from being perfected, the technic of operative procedure has been amplified to such an extent that growths that twenty years ago would have been uniformly fatal to-day are being successfully extirpated. The mortality rate will probably always be high following efforts at the removal of growths within the cranial cavity, but when we consider that every life saved is one that is absolutely restored to humanity and, that even where complete removal is unwise and not to be attempted, agonies of suffering are saved these unfortunates by the simple palliative methods, we should not weigh long in the balance whether or not we are justifiable in making any efforts that will promise relief. The average medical man has too long regarded the cranium as the "holy of holies" on which we should not lay profane hands, but the time has come when the halo of awe that formerly enveloped this sacred precinct is being dispelled by the light of science. Intracranial neoplasms are of much the same clinical varieties as are met with elsewhere; those produced by the infective granulomata exceeding the others in frequency while the endotheliomata come next. The most distinctive growth affecting nervous tissue is glioma and at the same time it is the most promising for relief, as it rapidly infiltrates the brain tissue, which it partly or totally destroys. Tumors make themselves manifest by local and general symptoms, though either group may be wanting, as for instance the case of growths involving a "silent" area of the brain the only evidence of disease would be general symptoms, the effect of pressure, while in the case of certain of the gliomata which destroy cerebral tissue in their advance, thereby making room for themselves, the only symptoms we would expect would be purely local, depending on the area of the brain involved. The general symptoms of tumor are headache, vomiting, optic neuritis or "choked disc", convulsions and vertigo. These symptoms are more or less common to all growths,

though any or all of them may be wanting. In certain cases, or rather in certain situations, symptoms which might be classed as general, such as the cerebellar gait, etc., are to be found, though really they are focal, as they are evidences of the exact situation of the growth and the result of local pressure.

I shall not attempt to give the technic of any particular operation for the removal of tumors from the brain, but will simply state that nearly all cortical growths are accessible and removable when not of the infiltrating type. Cerebellar tumors have given splendid results and even tumors involving the hypophysis cerebri, at the very center of the base of the brain, are being successfully attacked. Where it is deemed unwise to attempt the removal of a growth, palliative measures by means of a decompressive operation often yield the most satisfactory results. Of the various methods advocated and practiced, I believe the operation as done by Cushing is the most satisfactory. Here the bone defect is made through the split fibers of the temporal muscle and the cerebral hernia which we expect to follow is limited in its extent by the overlying muscle fibers. The physiology, or rather mechanism, of this is the same as in the grid-iron incision for the prevention of abdominal hernia.

Severe facial neuralgia is now being relieved by extirpation of the sensory roots of the trigeminus: abscesses deeply situated in the brain substance are being evacuated, clots of large size about the internal capsule, causing hemiplegia, are being made to extrude themselves through small openings and, in short, it seems that every surgical condition involving the cranial cavity must in time yield up to the surgeon some of its victims. I believe that the great workers in this field are destined to accomplish still more astounding things and that the cranial cavity must sooner or later be as open as a book to us as is the peritoneal cavity to-day.

Literary Notes.

We desire to call attention of the medical profession in Mississippi to the series of articles running in McClure's Magazine for December and January on the subject of the Montessori method of instruction for children. We have no desire to abstract any of these articles, feeling that every practitioner who is interested in children (and who is not?) will want to read and absorb the details of this, the first real advance since the development of the kindergarten idea. We

are so often consulted about the primary education of children, we are so often in a position to point out the backward one and give the simple advice necessary to aid in making them normal, that the knowledge conveyed in these articles is of vast importance to practitioners. Briefly, Madame Montessori while a teacher among the backward and idiotic children of Italy, developed a system of instruction which for simplicity, directness and unequalled results stamps her as a pioneer in the hitherto utterly neglected field of child instruction. Children are, even today, in the great majority of American communities, driven to the school corral at the age of six; after due pulverisation in the name of discipline by an untrained teacher are jammed like so much raw meat into the sausage mills and supposed to run out in well developed sausages, covered with a thin veneer of educational casing. Alas! for individuality. That is the secret of the Montessori method, which we urge all of our friends to read about in the current number of McClures.

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January is the beginning of the fiscal year of the Association and with its arrival comes the duty of furnishing the sinews of war for 1912, the payment of dues. This year the amount *per capita* that the county societies send to the Association is three dollars, an increase of one dollar over past years, due to the provision necessary for our defense business. As the plan has been described in detail to each member of the Association, it is not necessary to re-hash it here. We mention it only as a reminder and because it should prove the best inducement we have yet had to offer prospective members. If the Association men will really make use of it as an inducement to non-members, our roll should be materially fattened. It will need some little argument for the reason that damage suits are comparatively unknown in Mississippi, but this will not always be the case. In fact, there have been four damage suits threatened in Vicksburg within the past year and in no single one of them was the physician to blame, so far as the writer could judge from the examination of the patient in one case and conversation with the lawyers in the other three. In none of these has suit been actually filed, but this is due to the fact that the plaintiffs' attorneys received only discouragement at the hands of those physicians who were consulted. East Mississippi has, however, been less fortunate and there is now pending in Newton County a case, set for trial in March, against one of the best and most favorably known men in that section, a member of the Association for many years, on grounds that would be humorous were it not that the suit is a source of profound annoyance to a good man and an indication of a growing tendency that will in future cause similar annoyance to others. In this day of frequent law-suits, and frequently biased witnesses, there is no physician who can be sure that he may not need defense in the near future and, since such a suit cannot

but be in a measure detrimental to the defendant, for the exculpation can never overtake the lie, more than the money involved will he need the moral support of his profession. Further, lawyers will hesitate before bringing suit of they know the profession is at the back of the defendant, and the professional witnesses employed by the plaintiff will hesitate about going into court when they know that the Association is to furnish expert witnesses.

Membership in the Association will then, in future, lift a load of possible worry and annoyance from the shoulders of its members and when these things are explained they should help in increasing our membership. So tell them to your neighbor who is not a member and help him to become one. And when so doing, fail not to pay your own dues. You have until April first to pay them, but remember that your secretary is giving his time and labor, not for money, for we don't pay our county officers, not for honors, for he gets little praise and little support, but for the sake of the profession and the Medical Association. Don't wait for him to see you or write you; save this much time; send in your dues. He will appreciate it and will be able to give that much more time to the working of the society, so that you will be directly benefited.

Society Proceedings.

Clarksdale And Six Counties Medical Society met at Elks Hall, Clarksdale, December 6th., holding after noon and evening sessions. The following program was enjoyed by more than seventy members and guests:—"Hematuria," E. R. McLain, Cleveland; "The Prevention and Treatment of Malaria In The Negro Race Under Delta Conditions", W. B. Harrison, Whitney; "Some Puzzling Thoracic Symptoms In Acute Malaria", S. W. Glass, Dublin; "Two Cases Of Tetanus Neonatorum", L. D. Harrison, Clarksdale; "Venereal Prophylaxis", A. J. Jagoe, Clarksdale; "Two Or Three Cases", T. M. Dye, Clarksdale; "The Water Cure In Snake Bite", A. L. Chapman, Lyon; "Two Cases Of Spider Bite", B. H. Booth, Drew; "Pulmonary Tuberculosis", S. C. Cowan, Sabino; "Puerperal Injuries", J. W. Gray, Clarksdale; "Malignant Pellagra", C. E. Ellard, Vance; "Whooping Cough", H. C. Buck, Friar's Point; "The Treat-

ment Of Laryngeal Diphtheria", T. F. Clay, Tutwiler; "Health And Sanitation", W. S. Leathers, University, and C. W. Stiles, Washington; "The Examination And Diagnosis Of Neurological Cases", W. C. Somerville, Memphis, Tenn.; "A Five Hundred Word Method Of Obstetrical Asepsis", J. L. Andrews, Memphis, Tenn.; "Leucocyte Count And Its Value In Diagnosis", B. N. Dunavant, Memphis, Tenn. Following the scientific program, adjournment was taken to the Palace Restaurant, where an enjoyable banquet was held and the bodies of those present were refreshed by all manner of good things for which Clarksdale is famous while their mental cobwebs were swept away by a number of delightful speeches on subjects not strictly medical.

T. M. Dye.

Newton, Neshoba, Winston County Medical Society met Dec. 12th. at 7 P. M. in the parlors of the Newton Sanitarium. A paper on the treatment of pellagra was read by Dr. J. T. B. Berry This was followed by a general discussion of the subject, in the course of which Dr. A. M. Harrelson reported six cases of the disease. Officers were elected for 1912 as follows:—president, J. N. Whittle, Union; 1st. vice-president, A. M. Harrelson, Newton; 2nd. vice-president, T. E. Jarvis, Neshoba; secy.-treas., S. J. Majure, Dixon; censor, G. H. McNeill, Newton. The delegates to the State Medical Association are I. W. Cooper, Newton; E. B. Stribbling, Philadelphia, and Walter Spiva, Louisville.

S. A. Majure.

Warren County Medical Society held its annual meeting at the Board of Trade rooms, Vicksburg, Tuesday, Dec. 12th. Election of officers for 1912 resulted as follows: president, M. H. Bell; vice-president, C. J. Edwards; secretary-treasurer, V. Bonelli; censor for two years, B. B. Martin; censor for three years, H. B. Wilson. S. Myers was chosen delegate to the State Medical Association. The society voted the increase in dues necessitated by the adoption of the medical defense policy by the State Medical Association, of which the members all heartily approve, and some considerable discussion was developed concerning, and some changes made in, the future policies of the society.

V. Bonelli.

Personals.

Dr. B. Z. Welch of Woolmarket, the active and efficient secretary of the Harrison County Medical Society, has moved to Biloxi.

Dr. W. G. Allen of Newton, of the Newton-Neshoba-Winston Society, has moved to Wayside in Washington County.

Dr. E. K. White of Florence, a member of the Rankin County Society, has moved to Biloxi.

Dr. D. J. Williams of Ellisville, the president of the State Association, has moved to Gulfport.

Book Reviews.

DORLAND'S AMERICAN ILLUSTRATED MEDICAL DICTIONARY. A new and complete dictionary of terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, Veterinary Medicine, Nursing, Biology, and kindred branches; with new and elaborate tables. Sixth Revised Edition. Edited by W. A. Newman Dorland M.D. Large octavo of 986 pages, with 323 illustrations, 191 in colors. Containing over 7000 more terms than the previous editions. W. B. Saunders Company, Philadelphia and London, 1911. Flexible Leather, $4.50 net; thumb indexed, $5.00 net.

A new edition of Dorland is always gladly received for while we are sure that each edition is the best dictionary of its date, the additions to medical phraseology are so constantly being made as to necessitate an occasional revision—and Dorland has them all. We have been using this latest friend relentlessly for the past sixty days, keeping it on the desk within easy reach and consulting it on all occasions, and have not yet had it fail us—and judging from past performances by its forerunners we don't expect it to fail until many new words have been coined, which will be incorporated in the next edition.

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*SOME RECENT OBSERVATIONS AND LITERATURE ON PUS CONDITIONS IN THE ABDOMEN.

A. G. PAYNE M.D.,

GREENVILLE.

During the last few years a wave of conservatism has dominated the American profession in the operative treatment of acute infectious conditions and pus in the abdomen. Until recent years, the percentage following operations for gangrenous, perforated or suppurative appendicitis with peritonitis was so large that the recovery of these cases was looked upon as depending almost entirely upon the personal resistance of the patient; but we now recognize that the advent of increasing technical skill, a better knowledge of the pathology of the condition and the recognition of peritoneal resistance have caused a gradual diminution of the mortality in such conditions.

No operator has done any more or better work to put pus-forming lesions or urgent abdominal conditions on a substantial surgical basis than the late Joseph Price of Philadelphia, who gave up his life June 6th. on account of an acute infection of the appendix, and who succumbed four hours after an operation for the same. How much like the beloved Andrew Holder, who gave up his life, a few years ago, on account of the same condition, after having done so much good work himself along this line.

There has been no greater advance in any line of scientific work than that made by the clinician in learning to recognize local and general peritonitis and treat it so that the mortality of ninety per cent. which prevailed only a few years ago has fallen under favorable conditions and early operations to ten per cent. This has not come in a few months, but a few years, and follows the advent of increasing technical skill, a better knowledge of the pathology of the condition and doing surgery which is one hundred per cent. good, consisting, as it does, in the entire removal of the cause of the suppuration or the clos-

* Read before the Washington County Medical Society.

ure of any existing leak, the removal of any existing pus with irrigation or wiping and invariable drainage, after which the Fowler position and Murphy drip are instituted.

The surgical procedure in these cases should be the early and complete removal of all diseased structures, producing as little trauma as possible and avoiding too much walling-off with gauze and neddlesome work. The brilliant convalescence which so often follows the early and complete removal of an acute infectious lesion in the abdomen ever forbids incomplete work with its companions of prolonged convalescence, multiple operation, bowel obstruction, metastatic conditions, fistula, etc.

Goldberger, in the *New York Medical Journal,* in a recent article, reviews the changes that have come about in the treatment of peritonitis, and gives the various means of treatment and the resulting mortality during the past dozen years. Mikulicz's statistics, up to about the beginning of this period, could only show a decrease in mortality from ninety-seven to forty-three per cent following operation for peritonitis. As late as 1898, Carl Beck reviews his treatment of these cases as follows:

The peritoneal cavity is washed with a hot saline solution, the fibrinous flakes are wiped off carefully and extensive drainage effected by the use of iodoform wicks. He further reports that at that time he considered those cases fatal in which there poured forth a serus exudate of fecal odor upon incising the peritoneum.

L. W. Hotchkiss in 1906, reported three series of cases divided as follows:

First series twelve cases from 1895 to 1899, treated by free opening, more or less evisceration, saline irrigation and drainage. Eleven patients died.

Second series fifteen cases treated, rapid removal of appendix, free irrigation of pelvis and lower abdomen, with hot normal saline and closure of wound down to a small cigarette drain which led to pelvis and appendiceal site. No deaths.

Third series twenty-eight cases from 1902 to 1906, in which pelvis and lower abdomen were washed out with Blake tube, peritoneal cavity not drained. Five patients died. A comparison of the results of the treatment of the second series of fifteen cases with no deaths, with the third series of twenty-eight cases with five deaths, forces us to the conclusion that the drainage cases have an apparent advantage. The mortality rate in the Massachusetts General Hospital about this time, in five years, one hundred and sixty-one cases of general sup-

purative peritonitis from appendicular origin, was sixty-six per cent.

There was not any perceptible lowering of the mortality in these conditions until the Fowler position was instituted, which at once caused a lowering of the mortality rate. The importance of maintaining the patient in the Fowler position cannot be overestimated as this is the only means by which the pus and toxic products in the peritoneal cavity are kept in the pelvis where the absorptive powers of the peritoneum and lymph glands are much less than in the diaphragmatic region.

Following this important step in the after-care of these cases, came the Murphy drip, the value of which is inestimable, as the value of the absorption of so large a quantity of fluid is easily seen. It decreases thirst, supplies fluid to the tissues, increases capillary tension, promotes excretion and dilutes the toxines, all of which makes it a most valuable adjunct in the post-operative treatment of peritonitis.

Bevan, in the *Journal of the American Medical Association* of April 22nd. 1911, sums up the various treatments for peritonitis. A copy of this should be in the hands of every medical man in the United States to consult and ponder over when he has a case of pain in the abdomen lasting over several hours. There are many valuable points in his paper to help surgeons remember things in extreme cases, that come up seldom and are in time forgotten. Among these is the advisability of giving saline cathartics early after operation in order to prevent paralytic ileus, and thereby absorption of toxines from a paralyzed bowel. He does not mention, however, one drug which is used by a great many men to prevent gas pain by keeping up peristaltic action, and that is eserine, in one-sixtieth grain doses hypodermically, given four hours apart for twenty-four or thirty-six hours. One other means, in my opinion, which will be generally used in the near future in these cases, and is used at present by a good many, is irrigation with iodine solution, followed by normal saline solution, if preferred, but not necessarily. Some cases of general peritonitis from acute appendicular origin that I have recently operated upon, and in which I have followed, as near as possible, the deductions as laid down by Goldberger, Bevan and Bartlet, have given me gratifying results, not, however, without a stormy period within ninety-six hours as well as later pus effects during what we would consider the convalescent period. Mrs. W. White, twenty-five years old, had been suffering with pain in the region of the appendix for six days, though was up and about. Was taken very much worse at four A. M., at which time Dr. Oden-

eal saw her and advised immmediate operation, which was done at eight A. M. The appendix was enourmously distended and seemingly just about to rupture; free fluid in region of appendix; appendix ligated with silk and cigarette drain attached to stump of appendix with catgut and same ends of catgut brought out of abdomen along with cigarette drain and wound closed by layer method. Temperature at time of operation was 102°F., pulse 130 and bad facies. Temperature dropped to normal and pulse to one hundred during the day, which conditions prevailed for three days, at which time there was a rise in pulse and temperature. The drain was removed, catgut having been absorbed during the time, and following it came a pussy discharge, colon bacillic in character. The discharge kept up for one week, through this small opening, and patient made an uneventful recovery, leaving the sanitarium fourteen days from time of operation.

P. B., male, white, twelve years of age, was brought to me by Dr. E. R. McLean of Cleveland, suffering with peritonitis from a ruptured appendix. Rupture occurred Saturday A. M., operated eleven thirty Monday P. M. following. On incising the peritoneum over a mass in the appendiceal region, there poured forth a quantity of pus, the appendix and head of coecum were grasped by a large piece of thickened and gangrenous omentum, which was ligated and removed, as well as the appendix. The rupture of the appendix was not a half inch from its base, and had not enough sound tissue to insure a ligature remaining in place, notwithstanding which this case was treated as the other case, silk around the appendix, and one drain attached to base of appendix, one drain running to pelvis, and one to stump of appendix. This boy was quite ill for several days, enormous gaseous distention of bowels, and inability to move same. However, with the administration of sulphate magnesia by mouth, and sulphate magnesia and glycerine by bowel, with the final administration of sulphate of soda in one ounce doses by bowel, good movements were finally obtained. This condition lasted over a period of five days, and was followed seemingly by a rapid convalescence, when he began having pain in the center and lower part of the abdomen. The wound was still draining, so I treated the case on the expectant plan, waiting for some localization of what seemed to be a collection of pus. I made a rectal examination and found an abscess bulging into the bowel, and would have opened the abdomen, or made an incision through the bowel, the next morning after locating the collection, had it not ruptured into

the bowel during the night. There was no further trouble in this case and the boy made an uneventful recovery.

E. M., colored, female, thirty years old, was seen by Dr. Odeneal at six P. M. Fever, pain, rigidity and mass in region of appendix; was operated at seven-thirty P. M. the same day. The same conditions prevailed as to omentum, but appendix was gangrenous. Was treated in the same manner as the last case; stormy period for seventy-two hours, but came around nicely after getting bowels opened. Convalescence was soon established and the patient seemed out of danger, when a mass began to form in the region of the navel. This was left alone for a few days and was finally opened under a cocaine anesthesia, after which she went on to a rapid recovery.

These cases, as shown by the experience of most men, do best and, barring some localized pus conditions, get well without any secondary operation, provided there has been a thorough removal of all diseased structures, closing any existing leak and if adhesions are broken up at the time of operation, plenty of drains, maintenance of the Fowler position, with plenty saline by bowel, and not waiting, but beginning to give sulphate magnesia by mouth early, so there will be less tendency to ileus and absorption of toxines.

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*LEGAL MEDICINE.

H. O. LEONARD M.D.,

DODDSVILLE.

Having in recent years been called as a witness in several cases and having heard one good, competent, though modest, physician appear in a case and be made a buffoon of, actuates me to write this paper.

I know the irrepressible dislike and the qualms of feeling which a member of our profession has when he is placed on the witness stand. He realizes full well that a fool can ask questions that the wisest man in Christendom cannot answer. A bright, well-posted physician can easily be made a clown of by a lawyer who is not his equal in native ability or by cultivation.

We step out of our respective fields of daily work when we enter a forum of justice and we enter the place where the lawyer, by virtue of his work, is thoroughly at ease. We are

*Read before the Clarksdale and Six Counties Medical Society.

not at ease and are consequently placed at a disadvantage. So I think it behooves us to review some of the elementary principles of legal medicine.

Dr. Draper says that legal medicine teaches the application of every branch of medical knowledge to the requirements of the law.

The divisions are, first the English term Medical Jurisprudence, the French term, translated, is Legal Medicine, and the German term, translated, is Forensic Medicine. All of these have their respective elaborate definitions; but they are synonymous and to differentiate them is useless.

There are those who maintain that legal medicine, while it is worthy of attention, scarcely merits the dignity of a special and independent place in the course of medical studies. They say let legal medicine be considered under each department of teaching. Let the professor of chemistry teach the detection of poisons, the identification of blood stains and the composition of animal fluids. Let the anatomist discuss the identification of the human skeleton, the proportions of the body, the determination of age and sex, the effects of exposure and decomposition, all pertaining to personal identity. Let the surgeon warn against malpractice in treating fractures and dislocations, and describe wounds. Let the obstetrican discuss the duration of pregnancy, the proofs of living births, the diagnosis of rape, delivery and absorption. So on with every subject in the curriculum of any reputable medical college. But the chemist, the anatomist, the surgeon and the obstetrician is so imbued with his respective subject that he will hardly turn aside from it to discuss topics which, however important they may be, are more or less remote from his immediate themes. So the average practitioner of medicine must get his knowledge of legal medicine from some other source than from the above-mentioned professors.

He must acquire it from a specialist or from the works of a specialist.

There is some special training required of a medical jurist. He must have more than just an intimate knowledge of the science of medicine. He may talk glibly of his success as a diagnostician and relate in an apparently modest manner the wonderful cures that have been effected under the magical influence of his prescriptions, but when he gets on the witness-stand he will see that "medical questions", as a high authority says, "assume a very different aspect and reflect very novel hues when viewed in the glare of the court of justice from what they do in the mild light of the sick room or the hospital

ward." An instance is recited of the eminent Dr. John Hunter who stood, in his generation, at the very head of his profession. If sound and comprehensive medical knowledge could qualify any man to act well the part of a witness, we should certainly be justified in pointing to him as an example, and yet this accomplished man was obliged to confess that he could not give a satisfactory answer to a question put to him. He was the only medical witness called by the prisoner to rebut the charge of poisoning. The final proposition put by the Court was: "Give your opinion, in the best manner you can, one way or the other, whether upon the whole of the symptoms described the death proceeded from the medicine (Laurel Water) or from some other cause."

And Dr. Hunter's reply was: "I do not wish to equivocate, but I am unable to give a satisfactory answer." An entirely different history was a case in which Koch appeared. He was at that time a practically unknown physician in a small German town. While here his name came before the public as an expert in a poisoning case. It is asserted that the prisoner's conviction in this celebrated case was almost entirely to be credited to the remarkable chemical analysis and medical testimony of Koch, which attracted such general attention by their profound erudition that he was summoned presently to Berlin as a member of the Sanitary Commission and a professor in the School of Medicine.

The manner in which a medical witness should give evidence is quite superfluous, since experience shows that rules of this sort, like those given to prevent drowning, are invariably forgotten at the very moment when the individual is in a position where he needs them most. He should never be ashamed to say "I don't know." Nothing so baffles the troublesome counsel as such candor. But having once replied "I don't know," he should never allow himself to be drawn out by the skill of counsel.

All questions should be answered directly and without ambiguity. If possible the answer should be given in the monosyllable "yes" or "no."

He who says "I think" or "my impression is" is laying a trap for himself that will give him an endless amount of trouble, perhaps, and is liable to the imputation that he is a member of "a guessing profession." He should not use scientific terms to express himself. As we all know, our American system of selecting a jury makes the personnel of that jury an average aggregation of illiterates, who can with difficulty understand only the most simple language.

Expert testimony is not the kind of testimony that the average medical witness is called to give. However, as a witness, he will be asked as to his opinion of the extent of the injuries of his patient, or, if his patient died, if the injuries he sustained were the cause of his death. As soon as he expresses an opinion then he, wittingly or unwittingly, becomes an expert and opens the avenue for an indefinite number of questions. He is supposed, although he does not enter the case of his own volition, and certainly not as an expert, to be fully acquainted with the latest and most exact knowledge of the scientific matter of which he testifies in the case now pending. He must not have any bias or prejudice in the case. Strict impartiality, which is another name for rugged honesty, should be one of his chief virtues. Sudden death due to natural causes involves much of the practical work which forensic medicine undertakes. A person is found dead. The first question is: is this person dead? The next is: what was the cause of his death? Was it a case of suicide, homicide or accident? The answer to these questions may involve the liberty, perhaps the life, of a suspected person. The State demands to know them. Who can answer them save an "able, discreet and learned man in the science of medicine," for the practice of medical jurisprudence calls for all of these characteristics?

The medical witness will have to determine, at times, whether a rape has been committed. To tell in a virgin is a matter that is not accompanied with much difficulty, although spurious cases are reported, such as where a mother scrubbed the external genitalia of her daughter with a nail brush until they were excoriated and bleeding; then she made a false alarm of a committed rape. Lacerations on the body and around the mons veneris, with a ruptured hymen, and, possibly, with bruises on the body, all go to confirm that the sexual act has been effected by force. In a matron it is more difficult to determine that a rape has been committed.

Deaths by drowning will present themselves at times. Was the deceased drowned or was he the victim of some murderer and the body thrown in the water to hide the murderous act? Deaths from hanging, strangulation, gun-shot wounds, infanticide, all come up for an exact determining. The medical witness alone can clear up the doubtful points.

If two are dead from a difficulty, which of the two died first. A case is recited of Sir Ashley Cooper where he was called to see a man who was shot in the temple. Sir Ashley observed closely the general appearance of the room. He then

determined the attitude of the deceased when he was shot. He noticed the course of the bullet and judged from the external appearance of the wound the position of the assailant. He reasoned from this that the deceased was killed by a man who was left-handed. This led to a later conviction of a man who was a member of the household of the deceased and who was deemed a friend. While we cannot each be a Sherlock Holmes, still we can equip ourselves sufficiently to give a modicum of intelligence toward the conviction of a guilty party or toward the acquittal of an innocent man.

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*THE HEMORRHAGIC DISEASE OF THE NEWBORN.

S. C. SPENCER B.S., M.D.,

SHANNON.

For the past few months I have been a veritable Job. My troubles have been many and distressfully interesting. Among them were poor collections; sepsis; puerperal eclampsia; severed jugular vein; fractured olecranon—fragments three-fourths-inch apart—leaving as a pleasant memento of my confidence in Scudders's long internal splint, a beautiful "flail arm" to the manifest delight of one of my colleagues, who with the brazen effrontery, monumental egotism and blatant ignorance of surgery and anatomy characteristic of such self-laudatory quacks and charlatans, asserts on a free cursory examination, before means to break up ankylosis have been instituted, that my treatment was *in toto* radically absurd and woefully incompetent.

Leaving aside these insignificant pleasantries which are so frequent that they are commonplace, I shall endeavor to entertain you with a few paragraphs based on my 'bete noir' a case of spontaneous hemorrhage or the hemorrhagic disease of the newly born.

After a careful study of Kerley, Fisher, Zahorsky, Holt, Tulley, the *J. A. M. A.* and other authorities, I have come to the conclusion that, like our old friend, the much discussed and cussed pellagra, the etiology of this disease is actually unknown.

A small percentage of cases are associated with sepsis, syphilis, or are manifestations of hemophilia; the remainder can in no manner be connected with any of the three above-mentioned diseases. In two cases reported by Gaerter a short

Read before the East Mississippi Four County Medical Society.

bacillus was isolated which when introduced into the peritoneal cavity of young dogs produced a disease accompanied by hemorrhages similar to that seen in the infant. His views are sustained by Mapes who later conducted observations of a like nature.

The lesions accompanying this disease are nothing, scarcely, save hemorrhages from various sites and into various organs, and blanching from loss of blood.

The cardinal symptom is hemorrhage. From experience I would term it an uncontrollable hemorrhage, a mere ooze which defies all obstacles, from soot to ligature, grandmas to modern surgical attendants.

Holt says the hemorrhage rarely occurs after the twelfth day, usually in the first week, and from infants that present every characteristic of normality at birth. Cases are recorded that were circumcised a few days after recovery without any unusual loss of blood.

Townsend says the hemorrhage occurs most frequently from the following points in the order named: umbilicus, lungs, intestines, nose, mouth, kidneys, female genitals, subcutaneously. Of seven hundred and nine cases under his observation, Townsend gives a mortality of eighty per cent. Holt says no observer has seen more than one-third of his cases recover. The concensus of opinion seems to be that no case is to be regarded as hopeless, for perfect recovery has repeatedly taken place where it seemed impossible. The duration of the disease in cases which recover is usually one or two days.

In regard to treatment: Holt empirically recommends adrenalin by mouth and locally. Zahorsky gives calcium lactate and by hypodermic administers adrenalin and serum, fresh from the healthy adult. Fisher recommends fifteen to thirty cubic centimeters of sterile horse serum, subcutaneously, and reports excellent results. Tully adds ergotole and gelatin.

Locally all means are to be used: styptics, astringents, ligatures, compresses, fixation pins with figure-of-eight ligatures, drugs galore; in fact everything is mentioned except the actual cautery.

By letter and verbal communication the following gentlemen report no cases: Doctors Donaldson, Wicks, Cowden, R. G. Dabbs, Lowry, Orr, Spencer C. E. and W. C., Elkin, Bonner, Goyer, Anderson and McMillan.

Dr. Horton, formerly with Dr. McMillan of Guntown, reports a case under his observation at the Charity Hospital at New Orleans.

The child was apparently normal at birth and up until the twelfth day, when it begun to bleed from the umbilicus. Pressure, bandages, suture and adrenalin were of no avail and the child died the second day after the hemorrhage began. Post mortem was negative.

Doctors Carrouth of Chesterville report a case: white female, age twenty-four hours, continual ooze from the caput succedaneum which was large, the mother being a primipara. Compresses wet with ice-water, solutions of tannin, acetate of lead, alum, etc, were of no avail; a cap built up of strips of absorbent cotton dipped in silicate of soda effectually controlled the hemorrhage and the patient made perfect recovery.

Report on my case:

Baby F. Family history: no bleeder ever known on either side, three grandparents living, no history of cancer, tuberculosis or syphilis. Both parents apparently infected with hookworm. Mother, secundipara, affected with chronic malaria.

Personal history; infant born Aug. 4th. after normal labor, At birth excess of vernix caseosa, profoundly icteroid, double hydrocele, in weight and size normal.

As is the custom I returned at the end of seventy-two hours and found the mother and baby doing well. Mother reported the baby was good and gave no trouble.

Aug. 17th. at 8 A. M., the thirteen day, I was called to see the infant. Mother reported the cord had dropped off the previous evening at five o'clock and hemorrhage had started during the night, and after she and the grandmother, a typical old meddling hag, made for the express purpose of testing the physicians' patience, had tried soot, flour, singed cloth, etc., they decided something was wrong.

On examination found slight stream of blood exuding from the umbilicus; pulse and respiration rapid. Cauterized the bleeding point with silver nitrate; results *nil.* Applied compress; results *nil.* Pinched up the umbilicus with artery forceps and applied heavy tumor pedicle silk *en masse.* Asked father for consultant and left.

11:30 A. M. Found the stream of blood or rather film of blood still exuding from the umbilicus. My attention was called to the vomitus which was tinged with blood, bowel movement bloody-steaked, perhaps from the navel. Directed that two drops of adrenalin chloride solution—one to one thousand — and strychnine sulphate, one-hundred-and-sixtieth, be given by mouth every two hours. Applied adrenalin with no results. Left large hemostat applied to umbilicus for

twenty minutes but the blood flowed on unchecked. Reapplied silk ligature, endeavored to impress on the parents the gravity of the case, demanded a consultant and left.

4.00 P. M. Missed engagement with consultant on account of his having a labor case. Found infant blanched to the appearance of a yellow wax doll. Placed rubber dam over the pedunculated umbilicus, applied silk around entire mass, placed gauze over dam, strapped down tight with adhesive plaster, gave up case as hopeless and left. Baby died at 12 P. M.

The next time I have a case I shall try the serum, that being the only measure I didn't try that is recommended, and on my own initiative shall resort to the actual cautery.

As an interne in a hospital where the patients were mostly surgical I had treated surgical shock often, and had, assisted or unaided, stopped hemorrhage from tonsil site after tonsillectomy, from the orbit after enucleation, from the appendiceal artery after appendicostomy, from the ovarian artery after salpingo-oophorectomy, checked hemorrhage from the bowel and from the uterus, and, naturally, presumed I knew how to stop bleeding until I encountered this case.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

The Legislature is now in session and before it will be brought the several measures recommended by the State Medical Association, and repeatedly urged by all of the County Societies. These several measures, such as vital statistics, appropriation for health work, etc. are all of vast benefit and importance to the people of the state themselves, but the measure, it seems to us, of first importance, first to the people and then to the honor of the state, is the removal of that stigma, which this state alone in the Union possesses, namely, that any one can go forth and practise medicine without the evidence of a medical education. One of the first measures to be presented to the Legislature, is a bill requiring that all applicants for license to practice medicine shall possess a diploma from a reputable medical college.* This is no more than would be asked of an engineer, or an architect, that he present evidence of his qualifications before being allowed to practice, no more than is required of trained nurses, and yet our proud old state does not require it, but rather allows anyone, upon passing a Board examination, without any other qualifications, to go forth into the byways and practice upon the ignorant and the poor, for such poorly prepared practitioners do not go to the towns or cities to practice but rather get their experience at the expense of the women and children of the country side. How ridiculous must sound to them the ever recurrent plea that this provision is for the benefit of poor boy, who must make enough money to go back and get his diploma after having acquired experience at their expense! Also we hear the argument that the increased requirements are urged by the profession for the purpose of shutting out competition, whereas any thinking person would realize that the increased requirements will necessarily bring to the state a higher class of practitioners, a better trained class of young men, and so actually increase the competition for the older men. For the

selfish interests of the profession, the *status quo* is preferable, for the untrained fledglings are no competition at all, but the medical profession's aims are higher, and seek the people's good, though often balked in their purposes by the public itself. The Legislature has had this bill presented before, and it has been pigeon-holed, not because of its unworthiness but because, the average Legislator, perplexed by the numerous bills introduced, has really no time to devote to the careful consideration of every measure. They must specialize on some one or two lines, and naturally few take interest in abstruse subjects like medicine. We know the average Legislator to be honest, fair and patriotically determined to serve the state to the best of his ability. This is one of the great opportunities of the Legislature, fresh from the people, and with these facts in mind, we beg every member of the profession to write to his senator and representative urging favorable consideration of the bill to remove that blot upon Mississippi's fair name, the removal of the right to practice medicine without the possession of a diploma from a reputable medical college.

S. Myers.

*As we go to press we learn that this bill has unanimouly passed the Senate.—S. M.

Each year at our state meetings there is a considerable proportion of the essayists on the program who are notable chiefly by their absence. This is occasionally absolutely unavoidable but most frequently due to inertia and consequent failure to prepare the promised paper. This is such a well-recognized quantity that the writer, who has served on seven program committees, has always worked on the supposition that one-fourth of the papers promised will not materialize, except in the surgical section, and this is taken into consideration in preparing the program. That our Association is not alone in this distressful state of affairs is shown by the following clipping from an editorial in the *Maine Medical Journal*, which while more vicious in its strictures than we would care to be, is, in a measure, justified:

"Embarrassment of the committee by members failing to present papers, after having signified that they would do so, without adequate reason for their absence, is a matter we should not pass by lightly and such a member should be denied the privilege of presenting a paper before us until he is made aware that the word of a gentleman is usually sufficient. We may be considered antique in entertaining such an opinion, but when we remember the large amount of work that hefalls the scientific committee, to prepare a program, it seems as if each member of the Association should be willing to do his share."

It is not such a dreadfully hard job to prepare a program when one has had a little experience, so we do not speak from

the point of view of discourtesy to the committee, but failure in this matter by an essayist often works to the detriment of his fellow members, since men often arrange to attend some special session, occasionally coming from quite a distance to hear some special paper, and if the essayist fails to put in an appearance naturally feel aggrieved.

On these grounds, therefore, we would urge that the members promising papers should at least attach as much importance to the engagement as they would to one to a dinner, of which Lord Chesterfield is reported to have said that only death should prevent attendance and in such case the undertaker should be instructed to render suitable excuses.

Society Proceedings.

East Mississippi Four County Medical Society met in Tupelo Aug. 16th., President Elkin in the chair and Dr. H. M. Anderson of Tupelo acting as secretary. None of the essayists were present, but Dr. Bryan of Amory exhibited a boy of fifteen with paralysis and Dr. Elkin a fistula of the thigh in a young man. Both cases were freely discussed.

H. M. Anderson.

East Mississippi Four County Medical Society met in Houston Sept. 19th. 1911, Dr. J. C. Walker of Houlka, vice-president from Chickasaw, occupying the chair in the absence of the president and Dr. E. K. Guinn of Prairie acting as secretary *pro tem.* Dr. Walker read a paper on the etiology and treatment of diphtheria, bringing out some valuable points which provoked short, interesting discussions. This was followed by an enthusiastic talk on pellagra by Dr. J. R. Williams, dealing with the symptomatology and treatment of the dreaded disease, which provoked many questions and an interesting discussion.

E. K. Guinn.

East Mississippi Four County Medical Society met in Aberdeen, Oct 18th. 1911, President Dr. T. F. Elkin in the chair. The secretary being absent, Dr. R. M. Boyd was selected secretary *pro tem.* Members present: Dilworth, Bryan, Burdine, Feemster, Elkin and Boyd. An informal discussion of questions of great interest to organized medicine was held in a conservative way and good was undoubtedly accomplished. On motion of Dr. Bryan it was agreed that the secretary be instructed to notify the membership that each would be ex-

pected to make a public health talk to one or more schools on the day in November set apart by the state superintendent of education as public health day. The following resolution was introduced by Dr. Feemster and passed by unanimous vote.

Whereas our State Board of Health assisted by Dr. W. S. Leathers, as Director of Public Health and Hygiene, is making a splendid fight against unnecessary sickness and death, and notwithstanding a lack of adequate support by our legislature is accomplishing results which challenge our admiration,

1st. Therefore, be it resolved that we are proud of the personnel of the State Board of Health and assure them that we appreciate their untiring and self-sacrificing efforts and the wisdom and conservatism shown in their efforts, and that we congratulate them in securing the services of Dr. W. S. Leathers and thank him for his earnest efforts and express our admiration of his talents as a leader in the fight to protect the lives of our people. R. M. Boyd.

East Mississippi Four County Medical Society met at Amory Nov. 21st. in the offices of Drs. Bryan and Burdine, Dr. Elkin in the chair. Dr. S. C. Spencer of Shannon presented a paper on "The Hemorrhagic Disease of the Newly Born." Discussion from experience was limited but most of the members seemed to be thoroughly conversant with the literature of the subject, particularly Drs. Bryan, Feemster and Grady. Dr. Spencer in closing was particularly interesting. Dr. Bryan presented the case of peripheral neuritis shown at Tupelo in August, now much improved, and Dr. Burdine exhibited a case of varicose ulcers of the legs which had been twice operated before falling into Dr. Burdine's hands and is making a rapid recovery under bandaging. Several hookworm subjects and pellagra cases were shown. A dinner was tendered the members and visitors by the Amory physicians. Those present were: McMillan, Feemster, Bryan, Grady, Gurney, Elkin, Farrar, Burdine, Spencer and Underwood. The visitors in attendance were Drs. Walter Hood of Texas and W. V. Pruitt of Aberdeen. F. J. Underwood.

Holmes County Medical Society met in Lexington, Miss. at the office of the secretary, on the afternoon of Tuesday, January 9th. 1912. On account of sickness on hand among some of the members, and the bad condition of the weather and county roads, which kept those living in the country from coming to town, the attendance was not as large as was hoped it would be. But from the interest expressed by the members throughout the county, it is expected the society will have a prosperous year.

This being the annual meeting, no papers were read and only a business session was held. The meetings hereafter will be held quarterly instead of monthly, on the second Tuesday of January, April, July and October. Owing to the state association meeting on April 9th., the next meeting of this society will be held first Tuesday of the month. The president will soon arrange a programme for the occasion.

The annual dues of the county society being raised from $3.00 to $4.00, a letter was read from the secretary of the State Association explaining why the raise was made. This, briefly stated, is for the purpose of laying aside the extra dollar for the use of the council in defending proper suits for malpractice among the members.

A committee composed of Drs. Shepherd, Phillips and Mabry was appointed to draft suitable resolutions on the death of deceased members. Those who have died are Dr. W. S. Derrick of Goodman, who was president of the society at the time of his death, and Dr. H. Christmas of Tchula.

The following officers were elected for the ensuing year:— Dr. M. L. Pollard, president; Dr. E. C. Lucas, vice-president; Dr. S. A. Eggleston, secretary-treasurer; Dr. T. W. Foster, censor for three years; Dr. B. A. Shepherd, delegate to state association; Dr. A. D. Chester, alternate delegate; Dr. S. D. Austin, member auxiliary committee; Dr. R. E. Howard, member medical defense committee.

Dr. Pollard, the newly elected president, is one of the most prominent phisicians in the county. His home is at Thornton, where he does an extensive practice and is held in the highest esteem by all. Dr. Pollard has always taken an active interest in things pertaining to his profession and will use his best efforts to make the Holmes County Medical Society the best of its kind in the state. S. A. Eggleston.

Tri-County Medical Society held its regular meeting at the City Hall, Brookhaven, Dec. 6th. with the following members present: Arrington, Beacham, Boyd, Butler, Dampeer, Dickerson, Dodds, Flowers, Frizell, Higdon, D. W. Jones, Johnson, W. L. Little, D. W. Magee, M. M. Magee, T. K. Magee, Martin, McLeod, McRee, Purser, Ratliff, G. W. Robertson, W. W. Robertson, G. R. Robertson, E. A. Rowan, S. L. Rowan, Safley, Segrest, Wroten, Whitfield and Mayor Heuck.

No scientific program is undertaken at the annual meeting, but after a short business session, including the Treasurer's report and the President's address, the election of officers is held and a banquet follows. The address of President Dampeer reviewed the work of the year, in which he congratulated

the society upon the fact that at no meeting had they failed to carry out a scientific program worthy of the time and expense of every member attending. Secretary D. W. Jones then presented the report of the treasurer, which showed a healthy surplus on hand. The secretary sounded a note of warning to the older members that the society could not afford the absence of their wise counsel without depreciation of the scientific work, and called by name many who have been absent from roll call more than usual this year.

Election of officers followed, resulting in the selection of Dr. J. T. Butler for President; D. W. Jones for Secretary-treasurer; D. W. Magee, W. B. Patterson, S. P. Klotz, for Vice-president (the Vice-presidents are members of the Executive Committee); J. H. Johnson for censor.

The members and guests then repaired to the Gem Restaurant, where the annual banquet, under the direction of Dr. Frizell, chairman of the committee on entertainment, was held. The feast was enlivened by toasts and anecdotes, under the direction of Dr. McLeod, toastmaster. A general good time was had, and everybody went away determined that the next year shall be the best in the history of the society. Next meeting will be held at McComb, Feb. 6th.

D. W. Jones.

The following results of the election of officers for 1912 are reported from the county societies:

Adams:—J. C. French, president; J. S. Ullman, sec'y-treas.; R. D. Sessions, delegate; all of Natchez.

Attala:—J. J. Howell, McCool, president; J. W. Long, Sallis, vice-president; J. W. Allen, Kosciusko, sec'y-treas.

Choctaw:—W. D. Arnold, Ackerman, president; A. R. Nason, Ackerman, sec'y-treas.; A. E. Reed, Weir, delegate; J. D. Weeks, Ackerman, alternate delegate.

Clarke-Wayne:—J. A. McDevitt, president; Albert Hand, sec'y-treas.; both of Shubuta.

Clay-Lowndes-Oktibbeha:—W. R. McKinley, Columbus, president; Edward Lehnberg, Artesia, sec'y-treas.; W. D. Hubbard, West Point, delegate from Clay; J. W. Lipscomb, Columbus, delegate from Lowndes; J. W. Eckford, Starkville, delegate from Oktibbeha.

Harrison:—B. S. Hood, Bond, president; A. F. Caraway, Gulfport, vice-president; B. Z. Welch, Biloxi, sec'y-treas.; E. C. Parker, Gulfport, delegate; F. E. Rehfeldt, Moss Point, alternate delegate.

Jackson:—J. I. Evans, Pascagoula, president; J. N. Rape, Moss Point, sec'y-treas.-delegate; B. F. Duke, Pascagoula, alternate delegate.

Jones:— W. S. Cranford, Laurel, president; S. O. Smith, Ellisville, vice-president; W. S. Harper, Laurel, sec'y-treas.; J. R. Kittrell, Laurel, delegate; H. G. McCormick, Laurel, alternate delegate.

Lauderdale:—T. J. Houston, president; R. H. Foster, vice-president; T. E. Royals, sec'y-treas.; N. L. Clarke, censor; W. W. Reynolds, delegate; all of Meridian.

Lawrence-Jefferson Davis:—G. A. Teunison, Monticello, president; B. S. Waller, Silver Creek, sec'y-treas.; J. J. Stringer, Oak Vale, delegate from Lawrence.

Leflore:—H. L. Shannon, Itta Bena, president; D. S. Humphreys, Greenwood, vice-president; W. B. Dickins, Greenwood, sec'y-treas.; J. W. Armistead, Sidon, censor; J. W. Dulaney, Greenwood, delegate; A. G. Trotter, Greenwood, alternate delegate.

Marshall:— G. E. Johnson, Hudsonville, president; I. B. Seale, Holly Springs, vice-president; W. C. Elliot, Holly Springs, sec'y-treas.-delegate; C. Daniel, Holly Springs, censor-alternate delegate.

Prentiss:—J. C. Vandiver, Wheeler, president; J. S. Wheeler, Booneville Route. No. 7, sec'y-treas.; D. T . Price, Booneville, delegate.

Scott:— E. J. Rowe, Hillsboro, president; J. M. Townsend, Morton, vice-president; W. H. Pevey, Forest, secretary-treasurer-delegate.

Tate:—R. D. Williams, president; W. D. Smith, sec'y-treas.; M. C. Ellis, delegate; all of Senatobia.

Washington:—T. F. Willson, Arcola, president; J. J. Ferguson, Greenville, sec'y-treas.; A. G. Payne, Greenville, delegate.

Yalobusha:—S. E. Cooper, Water Valley, president; O. G. Coleman, Coffeeville, sec'y-treas.; J. C. Armstrong, Water Valley, delegate.

Personals.

Dr. E. P. Odeneal of Greenville has moved to Biloxi.

Dr. T. B. Lewis of Washington, Adams County, has moved to Greenville where he will be associated in practice with Dr. A. G. Payne.

Mississippi State Board of Health.

Governor Brewer has announced his appointments for the New Board as follows:

First district—Dr. Theodore Borroum, Corinth.
Second district—Dr. Samuel E. Eason, New Albany.
Third district—Dr. M. J. Alexander, Tunica.
Fourth district—Dr. Joseph C. Armstrong, Water Valley.
Fifth district—Dr. W. W. Reynolds, Meridian.
Sixth district—Dr. W. W. Hall, Lumberton.
Seventh district—Dr. C. E. Catchings, Woodville.
Eighth district—Dr. J. B. Jiggitts, Canton.

The following were elected from the state at large by the State Medical Association:

Dr. E. A. Check, Arcola; Dr. T. E. Ross, Hattiesburg; Dr. G. S. Bryan, Amory; Dr. I. W. Cooper, Newton; Dr. John Darrington, Yazoo City.

With the exception of Drs. Borroum and Hall, all the gubernatorial appointees are members of the Association. Dr. Eason is secretary of the Tippah-Union Society and councilor of the third district. Dr. Alexander was the first president of the Clarksdale and Six Counties Medical Society. Dr. Armstrong was president of the Yalobusha County Society in 1906 and represented it in the House of Delegates of the State Association in 1909 and 1911. Dr. Reynolds was a member of the House of Delegates in 1911 and will be remembered as one of the two who so gracefully declined to contest the election for president with Dr. Williams. Dr. Catchings has served four terms as secretary of the Wilkinson County Society and represented it four times in the House of Delegates. Dr. Jiggitts was president of the Madison County Society in 1908 and represented it in the last House of Delegates.

Book Reviews.

RETINOSCOPY. By James Thorington A.M., M.D. Sixth edition, revised and enlarged. P. Blakiston's Son & Co., Philadelphia. Price $1.00.

Thorington on retinoscopy is one of the small volumes which should be in the hands of every physician who fits glasses. The subject is a very important one and this small book covers it well. M. H. Bell.

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MISSISSIPPI MEDICAL MONTHLY

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MISSISSIPPI MEDICAL MONTHLY

VOL. XVI. MARCH 1912. No. 11

PRESIDENT'S ADDRESS, DELIVERED BEFORE THE TRI-COUNTY MEDICAL SOCIETY.

J. M. DAMPEER M.D.,

CRYSTAL SPRINGS.

As your retiring president, I wish, with your permission, to call attention to some things that I hope will not only be beneficial to ourselves, but to that larger class of citizenship—the men, women and children of our several communities. The Tri-County Medical Society, composed of the counties of Copiah, Lincoln and Pike, includes perhaps the three most populous and wealthy adjacent counties in the state. We justly take a great deal of pride in the material development of our country. It is true just at this time, when the boll-weevil is abroad in the land and labor agitations are disturbing our people, we are inclined to become pessimistic, but a bountiful harvest of other things has come to us and we have much to be thankful for. In return for all of this, and other blessings, how best can we serve those among whom we live?

To this discussion, for a brief time, I invite your attention. First, the doctor should be a Christian gentleman. Now we all know what that means. If a man sustains the right relation to his maker, he will manifest it in his relations to his fellow men. A man can be a gentleman and not a Christian, but he can hardly be a Christian and not show himself a gentleman. No physician can ever rise to great usefulness who holds his profession as a merchant holds his goods, to be sold for the money it will bring. Such a spirit as this will ever be an insurmountable obstacle in his way, debarring him from reaching the height of medical knowledge and medical influence. The responsibility of the physician embraces many duties. In a true sense he sustains a three fold relation: to his patients, to his brothers in the profession and to the community in which he lives.

I wonder if, at times, we are not unmindful of our duty to our patients. Carelesness in the discharge of this duty would

make the physician a criminal in the sight of God, a criminal unpunished by law. Every patient should receive the best attention it is in the power of the physician to bestow. If the case is more complicated than he can intelligently treat, it is his duty to the patient to call in the help of others—thus acting honestly and conscientiously, even at the sacrifice maybe of a little self-pride. Feel an interest in your patient and you will show it. It has been truly said "The responsibility to the patient combines thoroughness of preparation, cleanness of thought, calmness of brain, gentleness of manner, faithfulness of friendship and a profound consciousness of responsibility." How worthy this is of our consideration.

What should be our relation to our fellow practitioners? The golden rule is the answer: "Do unto others, as we would have them do unto us." The greatest drawback to physicians, professionally, one to the other, are petty jealousies. These jealousies are no respecters of persons, attacking alike the most unlearned as well as the most skilled. "Know each other better and you will love each other better," is as true to-day as when Lamar delivered his famous Sumter eulogy.

Associations in medical societies like this will help to develop friendship, tolerance and good will for each other.

When a young man first enters the medical profession he receives as a heritage from his profession, certain rights, privileges and immunities, which place him at once under obligations to his profession. When he unites with a medical society, he aids in medical organization, he becomes more broad-minded and liberal; it enables him to see his own short-comings, and also the ability of others. Such association will stimulate him to study and investigate, and he will help to unite, strengthen and elevate his profession. But when a physician selfishly isolates himself from his brother physicians, he fails to discharge his obligation to his profession and is bound to get into ruts and become unfitted for the highest discharge of his duties.

What then should be our relations to the public? Guardians of the public health always, there are many ways in which we can manifest this interest. Wholesome legislation in matters pertaining to public health is of the very first importance. To this end, I recommend that a legislative committee be appointed whose duty shall be to co-operate with like committees from other societies in getting the needed legislation. In this connection a little personal effort with the representatives from our counties will accomplish good results. Just here, I wish to most heartily commend the excellent work of our present State Board of Health. I wish to make no invidious

comparisons, but in results accomplished they have surpassed all previous boards. Health day is being observed by most of the rural and high schools. We should take advantage of these opportunities and discuss with teachers and pupils health matters, and what it takes to become strong, healthy men and women. This work of education must be done among the children. The youthful age is more impressionable, adults are much more difficult to teach, slower to learn and forget more quickly than children. This is a duty that we cannot delegate to some one else.

In conclusion, I wish to say the work of this society for the past year has not accomplished all that we had hoped and planned for. Still we feel that we have one of the very best societies in the state. Cordial good will and fellowship abounds with us.

In conclusion, I wish to thank our efficient secretary for his untiring zeal and labor in behalf of the society, and the rank and file, for their hearty co-operation and, above all, the honor conferred on me by having been your president.

---

*REPORT OF A CASE OF MALARIAL HEMOGLOBINURIA.

F. M. BROUGHER M.D.,

BELEN.

Early in January 1911, I was called by phone to see Mr. B., at a distance of about nine miles, who thought he was "threatened with hematuria." I was somewhat delayed reaching the patient, coming as I did from a distant patient in another locality.

When I saw the man at about four P.M. he showed the icterus, black water and other unmistakable symptoms of hemoglobinuria, dating from a chill very early in the morning, possibly during the night previous. His first remark was "Doctor, you once told me when I took hematuria to take a teaspoonful of calomel and send for the doctor. I took it and I have taken salts and my bowels have acted."

Then came what I term the long watch, for when I first see a typical case of hemoglobinuria with all its terrors of vomiting, stupor, uraemia, odors, etc., I cannot know when to leave him. I remain by his bedside three days and nights before going home. Only for a few hours at a time do I sleep

* Read before the Clarksdale and Six Counties Medical Society.

or go to any distance until favorable symptoms return, because I cannot trust attendants nor can any forecast be made. At six P.M. the patient had a terrific rigor, teeth chattered, etc. I gave calomel, five grains; strychnine, one-fortieth-grain; sparteine, two grains; sodium salicylate, two or three grains; all in one capsule, about four hours apart all night. We plied him with copious draughts of hot water to wash out the stomach and in the almost vain hope to control vomiting.

He was fed broths, ingluvin—he could not drink buttermilk which is my preferred food for all who will take it.

At about six o'clock next morning he suffered another rigor, just twelve hours after the first, and corresponding with the hour when black water first appeared—twelve hours intervals between rigors.

This patient was a new comer to the Delta having been here about four or five years. He had borne malaria badly from the first. I had not treated him for at least two years and he had called in another physician only once or twice during last summer for his "chills and fever."

The patient seemed to have become discouraged and had invoked the counsel of medical friends back in Nashville, Tenn., by letter.

He had insisted that he could fill himself full of calomel and quinine as well as the doctors could. This line of misconduct required only two years to develop hemoglobinuria in one of the finest physical specimens of young manhood I have ever seen come from the Tennessee hills.

He is an industrious, ambitious young man of very exceptional character and habits. Has never tasted whiskey, is married and has a young family of two healthy children. When the second rigor came, in spite of the vigorous, heroic dosage of eliminants and stimulants of the preceding twenty-odd hours, I was disappointed and perplexed to the last degree.

I had never before given quinine during the stage of black-water urine. Patient was given a capsule containing quinine-bimuriate with urea, ten grains, repeated so that he received fifty grains by the mouth during the succeeding twenty-four hours. The rigors did not return. Secretions from the liver and bowels responded well to the purgatives. Black-water showed for about five days before clearing. Vomiting became dangerously violent for two or three days and on one occasion I gave a hypodermic of morphine, atropine and strychnine; also, at the instance of Dr. Stephenson, gave tablets containing cerium oxalate, cocain and creosote. These agents controlled and gradually the patient's stomach got better.

Thus, I am reporting my first or second infraction of time-honored, ironclad rules among medical men of this region. The patient made a slow recovery, being more than a month getting up and out. During convalescence the temperature hung on at 100°F. to 103°F. at least four weeks after the color of the urine resumed normal. During the second and third weeks and into the fourth week, I gave at intervals the same ten grain doses of the same form of quinine with some small portions of calomel.

Sparteine I used, with strychnine, to sustain the heart-force, at intervals of four to six hours, continuously. Iron tonics and other reconstructives, panopepton, etc. He finally took some buttermilk every day. I believe this and one or two other cases under my observation will support the claim that there are cases calling for quinine in a form like the one used.

---

*ECLAMPSIA.

E. L. ROBERTSON M.D.,

SUNFLOWER.

In presenting this paper for your consideration, I first must enter an apology for my ignorance of the subject; yet in this I feel that I am somewhat excusable, as all writers, as far as the etiology is concerned, seem to be at sea.

For that reason I agreed to present a paper on this, to me, the scarehead of obstetrical work; so that by eliciting a liberal discussion from this association I may learn more of the subject, and be more fitted to cope with this disease, symptom, malady or anything you may care to name it.

The most horrible sight it has ever been my misfortune to witness, is to be called to a woman in the throes of eclampsia who has had no previous treatment, and to realize that you have thrown upon your shoulders the responsibility of two lives, for that to the laity is what it is, they never realizing that they have played any part in this drama of death in not employing a doctor when they first discovered the presence of pregnancy. So it has been and ever will be that the doctor must take the brunt of these deaths that occur from eclampsia until we have educated our clientele to the many dangers of a pregnant woman. I shall not attempt to enter into the pathology of this disease, as what I would say would merely be

*Read before the Clarksdale and Six Counties Medical Society.

a copy of the experience of others, as I have never had the fortune of a post-mortem.

The frequency of eclampsia is given by various authorities as one in two hundred and fifty to five hundred cases. It is said that the complication appears in one per cent. of all cases of albuminuria.

Theories of the causation of eclampsia are so many that they become confusing, and we stop to wonder that a disease so fraught with danger as this has not been more closely studied, and some one fixing the cause so forcibly that we may no longer speculate but be able to at once lay our finger on the seat of trouble. It seems that the prevailing opinion is that its origin is a manifestation of autotoxemia.

As to the source of this poison, whether maternal, fetal or placental, there seems a great difference of opinion. It was supposed in former years that the kidneys were the sole trouble. Later ideas seem to incline more to the liver as causative factor, because the symptoms suggest the highest degree of hepatic failure which produces lesions of the kidneys; and they in turn cause more or less interference with the renal function; therefore some say uremia should not be considered as a causative factor.

In my own obstetrical practice I have seen eclampsia in women who had not shown one symptom of uremia, and have seen others go safely through pregnancy who had almost every manifestation of it.

Others say that the extra amount of toxines coming from the child added to those of the mother, and the sewerage system of the mother remaining the same, there is an accumulation in her system which causes the disintegration of the kidneys found after death. So, as I have said, there seems such a diversity of opinions until it leaves me wondering "where am I at."

The symptoms of eclampsia are classed as prodromal, or the pre-eclamptic state, and those of the attack itself; and of the latter stage I think it can be said that one needs only to see them once to know what they are and be able to recognize them fifty years after. I shall have only a few words to say on the symptoms as doubtless all of you know them as well if not better than I.

The prodromal symptoms to the physician are the ones of greatest importance, but of how little to the laity is shown by the number of cases we have and the awful death-rate, which is given as from twenty-five to forty per cent. maternal and fifty to sixty-nine per cent. fetal.

And so will it remain until every doctor who does obstet-

rical work makes it his personal duty to impress the great importance of early employment, and then watch after his cases, and not do as many of us are wont to do, ask the expected date, promise to be ready and immediately forget it until we are called on a dark and stormy night and then "cuss" because it did not come off in the day.

As you all know there are certain signs of impending attack such as headache, visual disturbances, epigastric pains, dizziness, amblyopia, digestive and nervous disturbances, debility, swelling of lower extremities, albumin and casts in urine. These may be present for several weeks or months before the attack, which if not looked after and treated rationally give way to the stage of invasion or that of the attack itself. It is then, and deplorable to say, that in many cases for the first time the doctor is called, to find the unfortunate woman in convulsions or perhaps in coma or dead.

If living and another convulsion ensues, you will at once recognize the peculiar symptoms of eclampsia, twitching of eyelids and lips, widely dilated pupils, which are at first contracted to pin points, mouth drawn to one side, head rotating, contraction of muscles of back of neck which extends to trunk, finally becoming fixed in an opisthotonic curve. Arms rigid with thumbs in palms of hands, tongue partially protruded, which if not protected will be bitten, causing bloody frothy saliva. Loss of sensation and consciousness complete. After a few minutes she passes into a stage of coma from which she awakes knowing nothing of what has transpired. If death is to ensue the temperature rapidly rises; pulse is wiry, feeble and frequent and she remains semiconscious.

One will have little trouble in differentiating eclampsia from other causes as hysteria, epilepsy, apoplexy and meningitis.

As has been stated, the prognosis is very grave, especially as to the child. It may survive several attacks or the first may prove fatal. Many delivered alive die in the first two or three to four hours. Schauta has shown that after the death of the child all the disturbances decline, hence the sooner it dies the better the prognosis.

It is the consensus of opinion that the earlier in pregnancy the attack occurs the greater danger. From my own standpoint this seems to be unreasonable, yet I cannot go against statistics. But if delivery stops the per cent. of cases it does, then haven't we the greater advantage on our side if we have this curative factor. In my own practice the only two mothers I have lost were post-partum, one of a few hours and the other

of four days. It is also more unfavorable with dry hot skin, attacks close together, temperature gradually rising and patient unconscious between attacks. Reverse conditions are favorable.

The treatment is one of the often-told tales, but with what little success is shown by statistics. It consists of prophylactic and curative, of which we can readily see that the former is of much the greater importance, for with proper treatment in many cases the attack can be prevented. To successfully deal with this pre-eclamptic state the physician must first be employed in ample time, and be able to recognize the symptoms when he sees them, and give these cases his closest study. If we should all work as hard before as we do after we are in the presence of eclampsia, I am sure the death rate would be materially lowered. To successfully treat these cases, something more than an occasional examination of the urine and a few questions to the husband is necessary, for non-albuminuric eclampsia occurs in from nine to sixteen per cent. of cases, so we must watch all prodromal symptoms as closely as renal inadequacy. The treatment consists of elimination of toxines through the bowels, liver, kidneys and skin; stop all nitrogenous foods or reduce them to a minimum, which can best be done by an exclusive milk diet, and the emptying of the uterus if necessary.

My method of elimination is an occasional dose of calomel at night and daily doses of castor oil. I prefer the oil as I think it helps to soften up any fecal impactions which are very prone to accumulate in a pregnant woman. Some stimulating diuretic, such as cream of tartar, urotropin, diuretin, glonoin or anything that will suit the occasion. Copious drinking of water, out-door exercise, hot baths and, if necessary, packs. Some good iron tonic and something to aid digestion, if indicated. Every case is a law unto itself and each of us have our favorite treatment, but any of them will do that stops the absorption and promotes the elimination of toxines. If all these fail, then empty the uterus by whatever method is the safest to both mother and child, and produces the least reflex excitability. For this last reason, that of producing reflex excitability, the British school of midwifery advises against producing labor, which they claim is apt to precipitate convulsions. The curative treatment consists of controlling the convulsions, elimination of toxines, and if convulsions cannot be stopped empty the uterus as quickly as possible by the safest method. Medicines most commonly used to meet the first indications are ether, chloroform, veratrum, morphine and chloral. Yet I have

used all of them in one case of post-partum and never controlled the convulsions, as when I would let her come from under the anesthetic she would have one, and I gave it to her for twenty hours. It is said convulsions are rarely known when you have reduced the pulse below sixty with veratrum, yet in this case I reduced it to forty-five and they did not stop. I have heard it said that as long as the convulsions continue to give the veratrum, but when I get a pulse as low as I did in this case I prefer to see the patient die from the disease rather than my medicine, so did not try to carry it lower. In giving veratrum it is my plan to give twenty to twenty-five drops hypodermatically as my initial dose, as it is a drug very easily controlled by alcohol or morphine and I prefer the large dose to the half-hour ten-drop doses. If the pulse is weak and thready, I think morphine or H. M. C. and chloral are the remedies, or we can and often do have to combine them, while I do not think veratrum and morphine should be given together as they are physiologically antagonistic. For elimination calomel, croton oil, castor oil, salts by mouth, high enema of magnesium sulphate to which can be added glycerin and turpentine. Hot water or toddies, and wrap in blanket rung out of hot water to promote sweating. Glonoin and hot fomentations or cups over kidneys for diuresis. In fact we must work on all the eliminating organs of the body at one and the same time. Some advise venesection and injection of normal saline solution, which I think a very good idea but have never used it in this trouble. While doing these things it is my plan to send for a doctor, or as many as I can get, for no one man can cope with all the indications and successfully carry out the next step if indicated, and in almost every case it will be that of emptying the uterus. This may be done in the best way possible according to surroundings; by either mechanical or manual dilatation of the cervix, or surgical delivery, as Cesarean section or deep incision of the cervix. The two latter ways can only be performed successfully by a skilled surgeon, hence we of the country necessarily have to employ the first, dilatation. Of course, in this everything should be carried out as aseptically as possible.

It is said that, in sixty per cent. of cases, on delivery the convulsions stop and it is just here I wish to insert a question. If as is admitted by most authorities on this subject, eclampsia is caused from autotoxemia, matters not from what source, does it seem reasonable that this percent. or any of these cases should be rid of convulsions by delivery? It does not seem to me possible that the mere act of delivery would extract or

eliminate the poisons, set up activity of the liver, or diminish the degeneration in the kidneys. Taking this into consideration and having seen women whose livers have not acted in ten years, more or less, as we do see in this delta, with albumin and casts in urine and from two to three actions from the bowels in a week, living on nothing but bread and meat, pass through this state and in a few days be up and about their usual duties, does it not seem that this trouble is more one of reflex nervous excitability than any of the other causes? The toxines may and do add their prorata to the exciting cause but are they the prime factor? If this is so does it seem reasonable that a woman with none of the prodromal symptoms should enter labor and have eclamptic convulsions? Yet I have seen this very thing, as doubtless some of you have.

So I say we should go deeper into this if possible and once for all determine the prime factor or cause.

As you will doubtless see I have drawn on textbooks and writers on this subject for a great part of this paper, but as I have said it seems that all of us are in a rut, on eclampsia, so one must follow the other. We have these cases, they die or get well, and still we follow on.

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*A PLEA FOR THE PROTECTION OF THE INNOCENT.

H. C. BUCK M.D.,

FRIARS POINT.

We are prone to boast of our country and proudly pose as the most refined and cultivated nation on earth. We justly feel proud of the grand fight that has been and is still being made to conquer and eradicate the tuberculous disease. But if one will pause and consider existing conditions, he is inclined to the opinion that much of our boasting (to use slang) is "hot air". While we gladly admit much noble work is being done by our State Board and many others in the fight against tuberculosis, we must also admit that absolutely nothing is being done to conquer or check venereal diseases, which are conceded by all observers to be the greatest curse of the human family. It would seem too that the fight on tuberculosis is almost exclusively confined to cities and centers of population, very little if any pioneer work or work in rural districts is being done, but in this connection I gladly make an exception of our own

*Read before the Clarksdale and Six Counties Medical Society

State Board who are making an honest, earnest fight all over our state, but their fight is in its infancy. Quite recently a negro man fell on the streets of my town and died before a physician could reach him. This negro had been a victim of pulmonary tuberculosis for months, yet, up to within a few days prior to his death, the authorities had allowed him to drive a public hack and haul passengers to and from the railroad depot. The day after this man died I was called three miles in the country to see a negro man, whom I found dying with consumption, he died that night, while he had been sick for months he told me I was the only physician he had called upon and I saw him then for the first time. If either of these negroes had had smallpox or measles and been allowed to run at large there would have been a mighty howl from all points, yet they were infected with a disease more deadly and far-reaching in its effects and equally as contagious. Yet nothing seemingly was thought of it.

For several years past the cattle in different parts of our state have been infected with "Texas Ticks" and large numbers of cattle have died from "Tick Fever"; for several months the United States government has had men in nearly every county in this state, at a tremendous outlay of money, in an effort to eradicate the tick and save the cattle. How much has the government spent in our state, or in any state, to eradicate the tuberculous disease, or the venereal diseases, and save the people? It would seem that our great government places a higher value on and is more solicitous for the welfare of the cattle, than for the people of our country, especially our country people or those living in rural districts.

Not so very long ago a lady of one of the eastern states wrote the department at Washington that she had consumption and asked for information by which she could obtain relief. They wrote her they could do nothing for her; she died within the year. About the same time one of this lady's neighbors wrote the department that his hogs had the cholera and asked for information by which they could be relieved, which was promptly sent him and the hogs lived; the moral of which is, if you want the protection of the government be a hog.

We as physicians well know that a very large per cent. of men and boys who have passed the age of eighteen years either now have, or have had, syphilis or gonorrhœa or both. Writers on gynecology tell us it is simply appalling to find so many married women, and even young girls, who are affected with one or the other of these diseases, a very large majority of whom are innocent victims. We know too that there are in nearly every

town and community cases of tuberculosis, yet there is no law to protect the innocent and unsuspecting from the contagion; the tuberculous man or woman marries, unhindered by a word of protest from anyone. A man who has syphilis or gonorrhœa takes a treatment and through ignorance of the great tenacity of the disease and feeling he is entirely cured, marries, there is no law to prevent his doing so, no law to protect the pure and innocent woman, but who can foretell the woe and misery that is almost sure to follow! What is the remedy? It would seem to me that our only hope lies in painstaking and general education, yet when we study the environments of our so-called cultivated people, when we know that prudery and false modesty hold us as with a grip of steel, the task of educating the people along sexual lines seems a hopeless undertaking. Doctor William Lee Howard, says: "We are maudlin drunk on prudery." Indeed it would seem that we are. Some time ago I suggested to a lady, who is a very enthusiastic club woman, that it would be a good idea for her club to take up the question of "sexual hygiene." She told me afterwards that she introduced the subject at a club meeting but such a storm of protest arose that she was discouraged. These ladies, nearly all of whom are mothers, were so completely enveloped by prudishness and false modesty that they could not, or would not, recognize the grave importance of the subject. We have always been taught to look upon China as a heathen nation, and we, as well as other civilized nations, send missionaries to that country to convert those heathen to our religion and to our civilized customs. I quote from a recent issue of a daily paper as follows:—

"From the distant orient a foreign traveler has visited this country, he comes as the representative of the "Emperor of China," his purpose was to secure improvements for his people. While here he studied the customs of American people, the people themselves and their surroundings, when asked what impressed him as most remarkable in this country he replied, "the lack of honor."

In the *American Journal Of Clinical Medicine,* for January, is an article entitled "Immorality Among Our Women, The Causes Therefor, And The Remedy," in which the writer boldly asserts that "Immorality among our women is making forward strides to an alarming extent." Again he says, "There are women in the higher walks of life, women who move in the so called 'best society,' who are guilty of unnameable crimes, so that if the light were turned on them the women in the slums and the 'red-light district' would seem clean and almost angelic in contrast with these moral lepers."

Can these things be true? Surely there must be some grounds upon which these men base their opinions. Truly has a writer said that ignorance or innocence of vice is no safeguard to the young man or woman in this age, when it is so evident on every hand.

Some time since there was in the City of New York an exhibit where were displayed the many inventions and devices for the protection of human life and limb, as well as an exhibit of the best protection against the tuberculous disease, yet in all this display there was nothing to show that such a thing as venereal diseases ever existed, still less a suggestion as to any means by which the human family can be protected from the dread ravages of these diseases. Why is this and what is the remedy, or what can be done to overcome this indifference to the existence of a curse that claims untold numbers of victims every day? Is it not time that something was done?

At present there is a great deal being said about "Child Labor" and the great hardships inflicted upon the children of good work is being done to remedy this great evil. But strange to say—the advocates of this great reform are totally blind to the fact that these very children, living as nearly all of them do in crowded tenements, are exposed to a moral and physical blight far more deadly than the hardships of manual labor. While this is truly deplorable in that they never know the joys of childhood nor have an oportunity of being normal happy children, yet only their bodies are deformed; on the other hand the venereal diseases and their immoral surroundings cause the blight and ruin of both souls and bodies.

While we know late investigation has proven beyond a doubt that tuberculosis is not an hereditary disease and the children of tuberculous parents may escape the disease, we also know such children come into the world handicapped, as in nearly every instance they have frail bodies and delicate constitutions, hence are all the more susceptible to disease germs. On the other hand we know that syphilis is an hereditary disease and is passed from parent to child even two or more generations. Hence, my plea is not only for innocent, pure women and girls, but for unborn generations. I believe there should be laws regulating or controlling marriage and no man nor woman should be allowed license to marry without first being examined by at least two reputable physicians and obtaining from them a clean bill of health, especially as regards tuberculosis and syphilis.

In conclusion I will say this is not an original idea of my own but is being freely discussed and advocated by many thinking and observing men in nearly all parts of the civilized world.

*THE USE OF FLEXNER'S ANTIMENINGITIS SERUM : REPORT OF CASES.

S. T. WELLS M.D.,

ALLIGATOR.

Since the recent reports of the successful use of Flexner's serum, I have patiently waited for an opportunity to use it in a severe case of meningitis as I felt that we were helpless with the usual remedies in these cases and the latest authors advise only the use of the serum. I have had recently the opportunity to use it in three cases with excellent results.

Case I., B. S. female, colored, aged six years. Feb. 20th. 1911. Had been ill about ten days under treatment by another physician. What the treatment was, besides a blister, I do not know. Examination showed marked rigidity of neck and back muscles, hyperesthesia, loss of sight of left eye. Kernig's sign was present. Temperature 100° F. This was the fourth case in the family and a fifth was ill at the time of my first visit. Two of the previous cases had died and the third was sufficiently recovered to be up at this time.

Lumbar puncture was done, about ten cubic centimeters of fluid withdrawn and fifteen of serum injected.

Feb. 21st. Examination showed a very decided improvement. There was less rigidity and hyperesthesia was less acute. Another puncture was made, about five or six cubic centimeters of fluid withdrawn and another fifteen of serum injected.

Feb. 22nd. The patient was so much improved that further injection was thought unecessary. I saw her every day for several days and did nothing further except give small doses of potassium iodide, hoping to remove, if possible, inflamatory exudate and perhaps restore lost function of the lost eye. When last seen her general condition was satisfactory but there was little, if any, improvement in the eye.

Case II, female, colored, aged fourteen, sister of Case I. Had chill afternoon of Feb. 18th., followed by high fever and a very severe headache, constantly growing worse. When I first saw her there was marked retraction of the neck, the muscles of the neck and back were very rigid and hyperesthesia was intense. The slightest movement caused her to scream from pain. Temperature was 102° F.

Because of extreme opisthotonus puncture was somewhat difficult, it being impossible to flex the thighs and separate the

*Read before the Clarksdale and Six Counties Medical Society.

laminae of the vertebrae, but I finally succeeded, withdrew sixty cubic centimeters of very turbid fluid and injected thirty of serum.

Feb. 21st. The patient appeared in an even worse condition than on the previous day, retraction and rigidity being more marked and hyperesthesia extreme. Before making the puncture, one-eight grain of morphine was given as the patient was almost maniacal and had to be held in bed. I withdrew forty cubic centimeters of fluid and injected thirty of serum.

Feb. 22nd. Patient was slightly improved. Her mind was clearer, hyperesthesia lessened. Withdrew twenty cubic centimeters of fluid and injected thirty of serum.

Feb. 23rd. Gradual improvement. Withdrew ten cubic centimeters of fluid, less turbid than before, and injected thirty of serum.

Feb. 24th. Not more than three or four cubic centimeters of fluid, almost clear, were withdrawn and thirty of serum were injected.

Feb. 26th. The patient was greatly improved. Her neck and back were much less rigid, hyperesthesia was not noticeable and the amount of fluid passed by the needle was so slight that I decided to introduce some normal saline solution and permit that to escape. Fifteen cubic centimeters were introduced and but little returned. Fifteen of serum were then injected.

Feb. 28th. The patient was so much improved that I felt justified in discontinuing the use of the serum. Convalescence was slow but satisfactory. There were no eye complications and a few days later the only complaint was of weakness of the legs.

Case III, D. R., mulatto, male, aged forty-five, married, called at my office March 12th. complaining of headache and stiffness in the muscles of his neck and back, constantly growing worse since it began, forty-eight hours previously. He had recently lost a son from meningitis and was somewhat alarmed.

Examination showed stiffness of neck and back muscles, hyperesthesia slight, Kernig's sign marked, temperature 100° F. Light hurt his eyes. Puncture was easily made and fifty cubic centimeters of clear fluid were withdrawn. When thirty cubic centimeters of serum were injected, because of pressure, the patient noticed a peculiar sensation in the lower limbs which shortly extended to the waist. As he expressed it he "felt dead from the waist down." This soon passed away and he got off the table and sat on a chair. About an hour later

he walked to his buggy and went home. I have not seen him since but understood he was improving at last accounts.

This limited experience is of course not sufficient to determine the exact value of the serum but since the death rate before the advent of the serum was from seventy to ninety per cent. and now the cures by the use of the serum are in the same proportion I hope it will be used early in every case. We certainly need something more effective than the useless remedies of former days, when all we could do was to blister and wait for death to relieve the patient's suffering, or a kind providence to restore him to health.

I would advise the early use of the serum in suspicious cases, even before a microscopical examination is made. In case the microscope fails to confirm the diagnosis, no harm is likely to result. It is a very simple matter to make the puncture, which causes little pain. I did not use any anesthesia and had no complaints from the patients.

Personals.

Dr. W. E. Richards of Inverness has moved to Columbus where he is associated with Dr. W. R. McKinley in the McKinley Sanatorium.

Dr. S. C. Cowan of Sabino has moved to Nashville, Tenn.

Dr. T. E. Steen of Birdie has gone to Florence.

Dr. W. C. Hearin, formerly of Hillhouse, is now living in Belton, S. C.

Dr. M. E. Bridges, who for some time past has been living in Shubuta has returned to Bobo, a former location.

Dr. E. L. Hooper of Bobo has moved to Memphis, Tenn.

The following county-society elections are reported:—

Jasper:—J. O. Denson, president; C. E. Burnham, secy.-treas.; E. A. Denson, delegate; all of Bay Springs.

Yazoo:—E. G. Parks, Redmonville, president; G. C. Jones, Vaughans, vice-president; S. W. Purifoy, Yazoo City, secy.-treas.; W. Mecklin, delegate to state association; W. D. McCalip, Yazoo City, alternate; Jno. Darrington, Yazoo City, delegate at large.

Forrest:—L. B. Hudson, president; C. C. Hightower, secy.-treas.; J. J. Stevens, delegate; all of Hattiesburg.

MISSISSIPPI MEDICAL MONTHLY.

E. F. HOWARD B.S., M.D., Editor and Publisher.

S. MYERS M.D., Business Manager.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

The medical practice act has passed the Senate and the House and it is now up to the Governor to finish the work that will relieve Mississippi of the stigma of licensing non-graduates. There is every reason to believe that Mr. Brewer will do the right thing and that our bill will be a law in the near future.

Now that the dust of action has somewhat cleared away, and we can see "where we are at" it should be of interest to consider "all about the war, and what they fought each other for" and recognize those "who bravely fought" in behalf of the sick and suffering in Mississippi.

The action in the Senate was so tame as to be misleading, since the bill passed unanimously, but that reflects only the more credit on Drs. Kendrick, Donald and Rowan, to whose generalship such a condition of affairs was due. But if it was tame in the Senate, the skirmish in the House more than made up for it. At first blush it looked as if we had won with little trouble since the bill passed by a vote of sixty-five to forty-two, but Mr. Pittman of Pontotoc entered a motion to reconsider and then the real fun began. Mr. Pittman had acquired some ideas that carried a good deal of weight with some of his fellow members and when, a few days later, Mr. Simmons of Smith county entered a motion to table the motion to reconsider, he was defeated. This aroused our Liliputian member from Coahoma, Dr. S. W. Glass, who promptly invited "our friends, the enemy" to meet the physicians' representatives to discuss the bill. Unfortunately but few of the legislators attended the meeting but the physicians did some good missionary work on those few and then spent a couple of days in individual debate, known to the initiated as "lobbying," with every legislator whom they could corner, and but few escaped. Having seen Glass, Leathers, Barksdale, D. W. Jones, J. P. Conn, W. C.

Elliot, I. W. Cooper, C. W. Patterson, Rembert, Smithson and Wood in action, the writer is prepared to say that the Association need not be afraid to ask for any kind of legislation; we have the men who can put up the arguments. The result was that on February 22nd., which was a very suitable day for the purpose, when Mr. Simmons again called the bill, the motion to table the motion to reconsider passed by a vote of seventy-five to twenty-eight.

That all may know to whom this great public benefit is due, the vote is appended:—

In Favor Of The Bill:—

Alexander
Anderson
Barbee
Beacham
Boswell
Brame
Bramlett
Brown
Burrow
Bush
Cavett
Conn
Covington
Crawford
Crenshaw
Dabney
Darden
Denson of Clarke and Jasper
Denson of Leake and Winston
Denton
Eskridge
Gandy
Gillespie
Glass
Hamblen
Harvey
Harwell
Howerton
Jenkins
Johnston of Coahoma
Johnston of Lowndes
Johnson
Jones
Langford
Mallette
Martin
May
Mayes
McLeod
Minor
Misterfeldt
Montgomery of Leflore
Moore
Myers
Neal
Nicholson
Parks
Pearce
Pilkinton
Rees
Rice
Rodgers
Ruffin
Rushing
Saunders
Sheffield
Simmons
Simpson
Smith
Spraddling
Stubblefield
Tabb
Tate
Torrey
Walker
Watson of Washington
West
Whiddon

Laub	Williams
Lindsey	Womack
Locke	Mr. Speaker Quin
Magee	

Orrosed To The Bill:—

Benefield	Lewis
Childers	McDonald
Cotton	Milam
Davenport	Montgomery of Holmes
Doolittle	Mott
Ervin	Murphree
Evans	Nabors
Felder	Owen
Genin	Pittman
Going	Rencher
Griffin of Amite	Sharp
Hannah	Stephenson
Harper	Thompson
Houston	White

The bill that has caused so much comment, and for which the physicians of the state have been working so long and so well, as finally passed, is as follows:—

"Section 1. Be it enacted by the legislature of the state of Mississippi, That section 3682 of the Mississippi code of 1906 be and the same is hereby amended so as to read as follows:

"Section 3682. How License Obtained—Every person who deslres to obtain a license to practice medicine must apply therefor in writing to the state board of health at least ten days before the date of examination, and must be examined by said board touching his learning in the follow-branches of medicine—viz.: Anatomy, chemistry, obstetrics, materia medica, physiology, pathology, surgery and hygiene; and if the applicant be found by the board, upon examination, to possess sufficient learning in said branches, and to be of good moral character, the board shall at once issue him a license to practice medicine, which shall be signed by all members of the board present at said meeting: provided, that no applicant shall be granted a license until said applicant shall hold a diploma from a reputable medical college that requires a four years' course of at least thirty-two weeks for each session."

While we are under obligations to each and every one of the seventy-five legislators who stood by us so ably, we cannot refrain from making special mention of Mr. Simmons of Smith county. As a senator Mr. Simmons lead the fight that killed this bill two years ago, but since that time he has been, as he expresses it, "educated by the doctors," and as soon as it was discussed this year, warmly espoused it. He lead the fight for us when the measure was so nearly lost on February 17th. and again when the battle was finally won on the 22nd. The Association owes a debt of gratitude to Mr. Simmons that the *Monthly* takes great pleasure in acknowledging. Incidentally we owe considerable to the Smith county doctors for "educating" him.

Society Proceedings.

East Mississippi Four County Medical Society met at Tupelo December 19th, 1911, at 2 P. M., Dr. T. F. Elkin in the chair. Dr. Hugh Carter of Memphis read a paper on "Extra-Uterine Pregnancy" that was ably discussed by Drs. Bryan, Feemster, Gurney and Campbell. Dr. Willis Campbell of Memphis delivered an interesting lecture on the orthopedic treatment of anterior poliomyelitis, showing many diagrams and pictures. Drs. O. S. McCown of Memphis and W. J. Grady of Amory led the discussion. Dr. A. C. Lewis of Memphis read a paper on "Surgery Of The Eyeball For The Preservation And Restoration Of Sight," reporting operations of various kinds, and finally brought down the house by narrating an experience with a grateful charity patient. He had restored the sight to a negro, blind from double cataract, and repeatedly given him car-fare to come to his office for dressings. The day he dismissed him the patient said: "Doctor, you been so good to me, can't you give me some pocket change, cause I won't see you no mo' ". The paper was discussed by Drs. Walker and Feemster. Dr. S. C. Spencer read a paper on "Pellagra" prepared by his brother, Dr. C. E. Spencer, and a lively discussion followed. Dr. Feemster presented a clinic, a large, recurrent carcinoma of the axillary region. Dr. J. M. Foster presented an eye case. Election of officers for 1912 resulted as follows: for president, W. N. Reed of Itawamba; vice-presidents, S. L. Nabors of Itawamba, W. J. Grady of Monroe, S. C. Spencer of Lee, J. A. Donaldson of Chickasaw; secy.-treas., F. J. Underwood; censor, W. C. Spencer. A motion to make Tupelo the permanent meeting-place was introduced, discussed and withdrawn and the secretary was instructed to obtain an individual expression of opinion from each member. The society discussed at length the fact that northeast Mississippi should have the presidency of the State Association this year, not having been recognized for years, and the members expressed themselves as being solid for Dr. L. C. Feemster of Nettleton, and hope that with justice in their hearts and for the good of the Association the members will be glad to recognize our section and our man. Several speeches were made endorsing Feemster. He is a man of brains, tact and energy, an all-round good man of presidential proportions. The secretary was instructed to write to the secretary of every county society, asking favorable consideration for our favorite son. The ban-

quet that followed the meeting was a success in every particular. F. J Underwood.

East Mississippi Four County Medical Society met at Okolona Jan. 16th.; Dr. J. A. Donaldson of Okolona, vice-president for Chickasaw, in the chair. Owing to unfavorable weather, the attendance was small. The society was so fortunate as to have as a guest that "live wire," Dr. H. Boswell of Laurel, now in the field work. He was extended the courtesies of the floor and gave a talk on the work being done by the State Board; and was given a vote of thanks and made an honorary member of the society. An "experience meeting" was then held and the greyheads, being in a reminiscent mood, held the more youthful members agape for two hours and the meeting became so interesting that a night session was held.

F. J. Underwood.

Harrison County Medical Society met at Gulfport Feb. 13th. and was called to order at the Great Southern Hotel by President B. S. Hood, the following being present: Cox, Morris, Hood, Williams, E. H. Caraway, A. F. Caraway, Mrs. M. R. Caraway, Annis, Card, Richardson, Segura, Carroll, Hopper, Welch and Parker. Dr. Cox gave a very interesting account of his pellagra cases and a general discussion followed, the physicians present placing the mortality in their practice at at least ninety per cent. Dr. Card told of some interesting cases confined at the Insane Hospital at Meridian. Dr. Parker read a paper on "Some Surgical Conditions Of The Kidneys With Special Reference To Floating And Movable Kidney," and an interesting discussion followed, especial stress being laid on the necessity of an exact diagnosis. Drs. S. E. Dunlap and D. J. Williams were received as members of the society. It was decided to revise the fee-bill at the next meeting and have new copies printed. An invitation was extended to the dentists of the county to meet with us at the next regular meeting and to present papers on subjects of mutual interest. A committee of Drs. Williams, Morris and Parker was appointed to consider the feasibility of undertaking the post-graduate course as outlined by the A. M. A. A letter was read from Representative Chas. Rushing assuring the society of his support in the medical legislation introduced by the State Board Of Health. The secretary was instructed to write all members of the society, giving them the names of non-members living in their respective towns and asking them to secure applications for membership. B. Z. Welch.

Book Reviews.

A HANDBOOK OF PRACTICAL TREATMENT. In three volume. By 82 eminent specialists. Edited by John H. Musser M.D., Professor of Clinical Medicine, University of Pennsylvania; and A. O. J. Kelly M.D., Late Assistant Professor of Medicine, University of Pennsylvania. Volume III: Octavo of 1095 pages, illustrated. W. B. Saunders Company, Philadelphia. 1912. Per volume: Cloth, $6.00 net; Half morocco, $7.50 net.

The final, third, volume of this excellent work on therapeutics considers constitutional diseases, diseases of the respiratory, digestive, urinary and nervous systems, and diseases of the muscles and of the mind. This completes a handbook on practical treatment of diseases that is more comprehensive than anything yet published and one that will be found of inestimable value to every practitioner. There are upwards of ninety contributors to the three volumes, each writing of subjects concerning which he has special knowledge, and the result is monumental. "Of the making of books there is no end" and many of them fail to show any real reason why they should be made, but this is certainly one of the greatest exceptions to such a statement that we have yet seen and we take pleasure in recommending it to our readers.

E. F. Howard.

NOSTRUMS AND QUACKERY. Based on articles on the Nostrum Evil and Quackery in the *The Journal of the American Medical Association*, with additions and elaborations. Part I, Quackery. Part II, Nostrums. Part III, Miscellaneous. First edition. Cloth. Price $1; with individual's name on cover, 25 cents extra. Pp. 509, with 220 illustrations. American Medical Association, 535 Dearborn Avenue, Chicago.

Every physician whose patients ask for information regarding the efficacy of certain "patent medicines," advertising specialists or other quack treatments should have this book.

In the last few years *The Journal of the American Medical Association* has published a number of articles dealing with the "patent medicine" evil and quackery. The book "Nostrums and Quackery" contains all such articles, elaborated in many cases and embellished with numerous illustrations, while in addition it contains some matter never before published. We do not agree with the advice given by the A. M. A., to keep the book on the table in the waiting room, but find it extremely handy in the office.

E. F. Howard.

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DAN'L J. WILLIAMS, M.D., GULFPORT
PRESIDENT MISSISSIPPI STATE MEDICAL ASSOCIATION
1911—1912

MISSISSIPPI MEDICAL MONTHLY

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*ILLUSIONS AND IDIOSYNCRASIES IN THE TREATMENT OF MALARIA.

H. L. SUTHERLAND M.D.,

BENOIT.

Nature has been wonderfully generous in her gift of soil in the great Yazoo-Mississippi Valley, but like many others of her gifts, an embargo has been placed upon their enjoyment in the fullest degree, to remove which will require the toil, the ingenuity and scientific research of years to come.

The knowledge of the prophylactic use of quinine in malaria has been of great service to immigration there, and but for it I doubt if any permanent foot-hold would have been made until the later and greater discoveries of Koch and Finley had laid bare before us, like an open book, the whole scheme of the cause and manner of propagation of the disease. Even yet, we are on the threshold of a new era of health in our great "Delta", as it is named, because we have been slow to fully comprehend the full significance of drainage as a necessity to greater agricultural possibilities, and of prime importance to the public health.

Then our ultimate hope of freedom from malaria—both a preventable and curable disease, yet from which twenty-five per cent. of our mortality comes—must be in drainage; but for the present, at least, our main reliance must be in quinine.

Very naturally, then, we, as physicians, are interested in the methods of administering this drug, the proper dosage, the time and the means of getting it into the circulation with the least possible discomfort to our patients.

There is quite a considerable number of persons who have an idiosyncrasy, real or imaginary, for quinine, and their tribe seems to increase. These must be placated, for from them comes our mortality.

In many instances we are sorely beset by these illusions and idiosyncrasies, when we know it is of vital importance that

* Read before the Washington County Medical Society.

the patient be brought under the influence of quinine, no matter what the cost in discomfort, or even suffering, may be, choosing the lesser of two evils.

It being conceded that every case of malaria can be cured in its early stages, and that a warning is duly given of its approach, except in rare instances, it can be clearly deduced that with the safeguards with which we are familiar we can live in malarial localities with a fair degree of safety. This is proven by the fact that many live in such districts in the enjoyment of health, which cannot be ascribed to an acquired immunity, as one attack predisposes to another, rather than giving immunity as is the case in yellow fever.

There is a wide-spread, popular illusion that in the state generally termed "biliousness" with fever the taking of quinine will cause hemoglobinuria, and I must say there are doctors, too, who, holding this idea, wait from day to day to get the desired effect of calomel on the liver, while their patient's red cell count is dropping a million or more per day.

This hemolysis from quinine may occur in a negligible number, but no heed should be given it in estivo-autumnal fever, when every hour's delay in getting quinine into the circulation counts against the patient's prompt recovery.

Even after the appearance of hemoglobinuria, if the parasites are found in the blood, as frequently occurs, quinine should be given, and it may be given with impunity by deep intra-muscular injection. Those of us who attended the 1903 meeting of the A. M. A., in New Orleans, will remember the paper of Shropshire of Texas, whose routine treatment of hemoglobinuria was quinine by intra-muscular injection. Brem, of the Ancon hospital, Canal Zone, used this treatment with a low mortality from this disease.

I concede that good liver function is of prime importance in the treatment of malaria—is excellent preparatory treatment—but this can be accomplished as well, or better, if both calomel, or other purgatives, and quinine be given simultaneously.

I recently attended a girl six years old with hemoglobinuria, in whose blood the parasites were very numerous. It is of interest also to say that she had not been sick for ten months, and had taken no quinine, not even a chill tonic; had taken nothing except four grains of calomel and a dose of castor oil. As soon as I had made the blood examination I gave six grains of bimuriate of quinine with urea morning and evening by needle. Under this treatment her urine cleared and in three days both parasites and fever disappeared.

Another illusion indulged in by the profession generally is

that quinine to be effective should be given just before the chill, in the rosette stage of the parasite, or during their extra-cellular existence. Ewing states: "Most observers agree that quinine is active only on the young, ameboid forms, and hence should be administered a few hours before the chill." While I know this to be the most opportune time, yet, if I first see a case ten or twelve, or even twenty-four, hours after the chill, by which time the young parasites have found their way into new cells, I begin quinine without delay, with a feeling of certainty that I can ward off another chill and fever, although I can not prevent the destruction of the already infected cells.

Under such conditions, I have often, when the subject was in my own household, taken blood every four or six hours, have watched the growth of the parasites to maturity, and while the process was delayed sporulation did take place, without chill or fever, and no parasite could be found for weeks after.

Old practitioners remember that before we knew anything of the plasmodium malariae, or how the antiperiodic effect of quinine came about, we thought it unnecessary and unsafe to give quinine until after the subsidence of the fever, yet we confidently hoped to avert another paroxism. My rule is to begin quinine at once in estivo-autumnal fever, and at the same time give calomel or other purgative as indicated.

Another very common delusion, and the one of all others most harmful to our section of Mississippi, is the impression that almost every inhabitant has malaria, and that it prevails winter and summer.

This idea comes from the habit of calling every chill followed by fever malaria, and dosing the subject with quinine. If the truth were known, and it can only be known by blood examination, we would find ourselves giving about half as much quinine for its anti-malarial effect in our fevers. In the winter and spring months, especially in the absence of a history of malarial fever in the preceeding fall, when a chill with fever presents the features of malaria, it is best to delay a diagnosis until a blood examination can be made.

Nearly every case of incipient tuberculosis, with its daily evening rise of temperature, has undergone the therapeutic test of quinine.

Disturbances in the digestive tract are frequently ushered in with a chill followed by fever, calomel and quinine are given, a cure is effected by the treatment, and the diagnosis of malaria is confirmed. It is remarkable how closely septic fevers simulate malarial attacks. I well remember a patient many years ago who regularly every morning, from four to six o'clock, had

a severe chill, followed by intense fever lasting six or eight hours, whom I treated with quinine, administered in every conceivable way, for six days, and then made the discovery that he had an endocarditis of gonorrhoeal origin.

I have known visitors to our country to develop a chill, followed by fever, who had not been with us long enough to have by any means acquired malaria in that stage of development, to fly as from a plague-stricken city.

Therefore, for the general good of our section, physicians should be careful not to fall into the careless habit of naming all fevers malaria.

There was an illusion very generally indulged in, not only by the laity but as well by practitioners, when as a young doctor I took up my residence in the Delta in 1873, that the drinking of whiskey in moderation tended to protect from malaria. It goes without saying in this day of enlightenment that no physician, who is not an antediluvian, subscribes to any such fallacy, but there are still a great many men, not of our profession, who believe, or pretend to believe, that whiskey tends to ward off malaria.

There are two potent reasons why we should teach temperance in malarious countries. One is that there is no such habit as moderate drinking, and the other is that there is no worse combination of disease than a whiskey liver and severe estivo-autumnal fever. Whiskey has no power to keep out malaria; on the contrary, it opens the portals for its admission.

This "jumping at conclusions" in the treatment of fevers in the Yazoo-Mississippi Delta has done much to retard white immigration and the best development of its resources by intelligent hands.

In my early practice in the Delta, when consulted for malarial fever (and every fever then was malaria, either as prime cause or accessory) by an adult and sane person, if confronted with the statement that quinine could not be taken at all, my usual advice was to emigrate. Not so now, however, and I believe there are no instances in which quinine can not be taken in some form or "somehow".

In my clientele is a woman, sensible, charitable in judgment and obedient to her medical adviser. She has a real idiosyncrasy for quinine. About seven or eight years ago it became necessary to give her quinine, and I prescribed it to be taken by mouth in capsules. After taking six grains I was called in and found her almost in collapse; pulse feeble and slow, countenance in anguish, violent tetany of both hands and feet, clonic spasm of abdominal muscles and constant nausea. I had the

temerity once since to give her quinine by mouth, and with like effect. During the past summer she began having fever on alternate days, and on my second blood examination I found parasites.

I advised quinine hypodermically and she consented, provided I would stay near her. I gave nine grains of bimuriate with urea in normal salt solution with antitoxin syringe (which holds 10 cc) deep in the gluteal muscle at 6 P. M. and twelve grains the next morning at 8 o'clock. She had no fever that day, nor any ill effects, except that she felt drunk, and has passed the summer without further trouble from malaria.

Under my care now is a girl four years old, who from infancy has been singularly effected by quinine given by mouth. She does not seem uncomfortable, but is in a nervous excited state and keeps the parents busy all night. Given hypodermically, she sleeps soundly and gives no trouble. After one treatment this the way the mother always asked that quinine be given hypodermically.

Erythema and urticaria are of very frequent occurrence in the administration of quinine, and can, in my experience, be avoided by deep intramuscular injection of a diluted solution of bimuriate.

Amaurosis has been classed as an idiosyncrasy, but from the case reports that I have seen, I think enormous doses of the drug caused the trouble.

There is no doubt some suffering accompanies the injection of quinine, but when we reflect that it is the most certain of the few specifics in medicine, and we can guarantee a cure if the patient submits to the discomfort and pain, it makes it worth while.

For these reasons, it is a great pleasure to practice medicine in the Yazoo-Mississippi Delta. Our chief disease being both preventable and curable, there is no sufficient reason why any intelligent person should die from it, and not nearly so many of our people die from it as is generally supposed by those who do not dwell in our valley.

We are scarcely aware of the presence of typhoid fever, which carries away so many in the so-called more favored hill countries, and we have few epidemics of the infectious diseases of children.

I have recently been investigating the mortality of white school children in the Delta, for a period of twelve months beginning October 1st. 1908, and have found that out of two thousand six hundred and eighty-eight children between five and eighteen years in Bolivar, Coahoma and Washington coun-

ties, the mortality has only been three and nine-tenths per cent. per thousand from all diseases.

As this illusion of the constant presence of malaria in our Delta has acted to very seriously retard its material progress and development, we, as physicians and public spirited citizens, should do all in our power to counteract these erroneous impressions. We should cease to call every chill followed with fever malaria, whether in season or out of season.

My experience every year strengthens my convictions that malaria, during the winter and spring, is exceedingly rare, notwithstanding a close resemblance in clinical expression, and if you don't care to make microscopic examinations of the blood to verify a diagnosis of malaria, you can at least withhold quinine for a few cycles of the plasmodium, and take my word for it your case of malaria will rapidly diminish, and at the same time your clientele will talk less about malaria at home and abroad. We, the doctors, are responsible for this illusion, and we should correct it.

INDICANURIA AND ITS IMPORTANCE TO THE GENERAL PHACTITIONER.

JNO. C. HERRINGTON M.D.,

ASYLUM.

The presence of indican in the urine was first observed in 1853. Since then various degrees of importance have been ascribed to its presence by the different investigators.

Certain bacteria in their biologic processes have the power of forming indol from proteid substances. This is a common cultural characteristic in the test-tube. The same process may take place in the human body. According to the field of bacterial activity, the source of the trouble may be extra-intestinal or intestinal. The former type may be due to a gangrenous lung, an empyema, a putrid placenta and certain other septic conditions which are easily diagnosed, hence this form has but a passing interest for us. The intestinal type is of great importance. There is a certain amount of putrefaction going on in the intestine all the time, except in the new-born. The indol thus formed is absorbed and oxidized to indoxyl, which in the blood is converted into a sulphate, and circulates as potassium-indoxyl-sulphate. The amount eliminated is small normally, being given at from 0.005 to 0.0025 mg. for twenty-four hours,

on a mixed diet. The amount is smallest on a milk and largest on a meat diet.

There is a prevalent idea that indicanuria goes with constipation. Constipation may act as a predisposing cause, but indicanuria does not occur in a simple case. When indican occurs in the urine to any marked extent one may rest assured that conditions in the lower part of the small intestine have been considerably altered from the normal. Not long ago I examined a specimen of urine collected from a patient who had a chronic diarrhœa of several months duration. The reaction for indican was strong even after a one to twenty dilution with distilled water. In some cases where the intoxication is great there may be a slight albuminuria which disappears when the putrefactive process has been eradicated.

Formerly the generous mantle of "biliousness" was generally spread over the symptom-complex arising from intestinal putrefaction. There are headaches, nausea, loss of appetite, lack of energy, etc., that the laity know by rote.

An intestinal indicanuria may result from the following conditions: A. Impaired functions of the stomach. In hypochlorhydria and anachlorhydria, notably in gastric carcinoma. Also in hyperchlorhydria occasionally, and sometimes in gastric ulcer (Osler). Simon attempts to explain the paradox by saying that with the hyperchlorhydria there is perhaps an associated atony of the stomach wall.

B. Biliary insufficiency, since the bile acts as an intestinal antiseptic, and as a stimulant to peristalsis. It may be due to either a deficient secretion or to an occlusion of the common duct.

C. Impaired peristalsis in the small intestines. Volvulus and acute and chronic peritonitis give rise to very large quantities of indican. In ileus the quantity may be extremely high, which fact is of great diagnostic importance.

The test for indican is very simple and easy. All the apparatus that is needed is a common test-tube about six inches long. The reagents are: a small bottle of chloroform and a six ounce bottle of Obermeyer's reagent. The latter is a two pro mille solution of ferric chloride in concentrated hydrochloric acid. This keeps indefinitely.

To make the test, pour the urine in the tube to the depth of about two inches. Then add an equal amount of Obermeyer's reagent, shake up and allow a few moments for the completion of the oxidation. Add chloroform to a little more than fill the rounded bottom of the tube and mix but do not shake violently. Allow the tube to stand for a short while.

The chloroform extracts the blue color and settles to the bottom of the tube. The color will vary in depth from a light blue up to the darkest indigo. The specific gravity must be taken into account, as a strong reaction with a low specific gravity would be of more significance than it would be if the urine were concentrated.

This is the simplest of the numerous methods of making the test for indican.

Formaldehyde cannot be used to preserve urine for this test as it interferes with the reaction. For this reason it is well to know if the patient has been taking hexamethylenamine, a part of which is broken up in its elimination with the consequent liberation of formaldehyde. Hexamethylenamine is commonly sold under the trade names of "urotropin," "uriform," "aminoform," "uritone," "formine," etc.

A red reaction is obtained when the patient has been taking an iodide. In that case, pour off the supernatant fluid and shake up the residue with a little strong potassium hydroxide solution. The iodine reaction will then disappear and the indigo blue present may readily be seen. Codein will also give a red reaction. A purplish hue may result from the presence of potassium-skatoxyl-sulphate.

The test for indican is badly neglected, and because of this fact I have taken the liberty of mentioning it again, hoping that by "line upon line" it may be brought into more general use.

By making the above test a routine procedure it will be found to be of the greatest value. It gives a valuable side-light on many of the obscure conditions that we are constantly encountering. Cases of intestinal putrefaction are constanly coming up and it is important to be aware of the condition and to obtain some idea of its degree. It is worth while to lay to heart the words of Simon who said:—"I maintain that an examination of the urine in this direction is at least as important as the testing for albumin and sugar, and that points of decided importance not only in diagnosis, but also in treatment, may thus be gained."

The Chicago Medical Society is arranging for a meeting to be held April 17th. to 19th. "for the purpose of discussing mental diseases in their various phases." Papers will be read by a large number of noted alienists. The invitation is general. Address, for further particulars, Dr. W. T. Mefford, 2159 W. Madison St.

*PELLAGRA.

E. G. MARTIN M.D.,

BENOIT.

This disease is nearly two hundred years old, appearing first in Spain in 1735, later appearing in Italy where it is still endemic. There it appeared almost exclusively among the peasantry, whose diet was principally maize, and the disease was attributed to a toxine in the unwholesome grain.

The latest investigations tend to prove that it is a protozoon disease and that it is transmitted like malaria and yellow fever by one of the mosquito or gnat family, the simulidae or sand fly. This is a very small stinging gnat and can pass through the ordinary mosquito bar or screen, is found only in the country and inhabits sandy districts.

This disease affects the gastro-intestinal tract, skin and nervous system, but it is essentially a nervous disease. Post-mortem shows degeneration of the posterior and lateral tracts of the cord, and inflammatory changes in the brain, hyperæsthetic and anesthetic areas, itching formication, symmetrical lesions, nervousness, insomnia, atoxia and finally dementia stamp it as a nervous affection. Rawness of lips, salivation, gingivitis and stomatitis, anorexia, indigestion, diarrhœa and rarely constipation, are the principal gastro-intestinal symptoms. The first skin symptom is erythema, or in the negro race a pigmentation which cracks, scales and finally ulcerates. These lesions are in my experience *invariably* symmetrical, and affect the skin in the following order as a rule: hands, neck, face, feet, genitals, breast and arms. The lesions on the hands are usually the first symptoms to attract the attention of the physician and he will often get a history of sunburn on face or hands for one or more summers previous.

In the older patients the nervous symptoms seem to predominate and three cases that I treated specifically during the winter, two for constant headache and one for nervousness and incoordination, showed up in the spring with the regular pellagra syndrome.

There is nothing easier to diagnose than a frank case of pellagra but we will often be surprised to find that nervous and cachectic cases which have haunted our offices and resisted iodides and mercury in increasing doses are nothing but pellagra.

This disease resembles syphilis in so many respects and is

* Read before the Clarksdale and Six Counties Medical Society.

so often engrafted on old syphilitic cases that I was inclined at one time to believe it was para-syphilitic. On the other hand, it resembles the tropho-neurotic form of leprosy as to anesthesia, hyperesthesia, parathesia, ulcerations and cachexia. And then we often see a house infection where three or more members of a family are affected. I have this year seen three cases in one family, two in another and three in another, and last year I saw three cases of Dr. Williams in one family.

It is only in the last decade that the disease has been noted in this country, so we have very little literature on the subject, but it is increasing so rapidly all over the country and particularly in the south that it is bound to force itself on the attention of every general practitioner.

Cases are very common in the insane asylums, many probably being sent there for dementia. In this state it was first noted in the eastern section. The first case diagnosed in Bolivar County was, I think, that of Dr. Rhyne of Beulah in the summer of 1909.

Last summer Dr. Williams and myself each saw five or six cases. There had been one or two cases, a year or so previous, which we failed to diagnose. The prognosis in this disease is almost invariably fatal, the symptoms disappear with cool weather and reappear in the spring, becoming graver each time and terminating in from three to five years.

Last year my treatment was symptomatic, with the result that all the bad cases died and the mild ones made an apparent recovery in the fall.

A few months ago I noticed an article by Dr. E. H. Martin of Hot Springs, Ark. in which he formulated a new treatment and which seems to give some hopes for combating the disease. It is the hypodermic administration of one of the aryloarsenates, soamin, almost chemically identical with atoxyl but seemingly without its toxic effects. The drug is administered every other day in doses of from one-and-one-half to five grains, until one hundred grains are taken, and after a lapse of a month another course is given if needed. Dr. Martin thinks it should be persisted in every summer for three years. The drug is readily soluble in water and should be administered deep in the muscle of the arm. Some patients complain of only slight pain just after administration while others have severe pain for twelve to twenty-four hours. I have never seen abscess following its use and have used it in about fifty cases of syphilis and eight of pellagra. The patients sometimes complain of insomnia and nervousness from its use, which may be met by a dose of bromide at bedtime. One case has incoordination but

I think it due to the disease rather than to the drug. Outside of this I have seen no toxic symptoms, though I use the maximum dose always and in cases where salvarsan would have been contra-indicated.

Dr. Martin has just written me that salvarsan gives much more rapid effect in the skin lesions but that its benefits are temporary and that it must be followed up with soamin. The drug must be given regularly, a week or two missed in the treatment will cause a recrudesence of symptoms. The mouth begins to heal up first, the skin lesions gradually heal but the nervous symptoms are most persistent.

Dr. Martin reports cases that have been free from symptoms through the second summer, and all made apparent recoveries except one who was in a moribund condition when first seen.

From my brief experience with the treatment I am not inclined to be as sanguine as Dr. Martin, but it is the only treatment so far offered that gives any hope even of amelioration of symptoms, so it is worth trying out. I have used it in cases of weak heart, nephritis, amaurosis, in fact all kinds of old tertiary syphilitics without any toxic effect, so can infer that its use is reasonably safe.

All cases seen so far have been colored, males and females about equally affected, and from childhood up to old age. One case gave a history of having never used corn meal in any shape or form.

I will give a brief history of some of my cases:

J. P. mulatto, male, age fifty, came under my treatment during the winter for rheumatism, vertigo, weak vision and slight incoordination. Used iodides in large doses, also soamin twice a week up to thirty grains, thinking the case specific trouble. All symptoms were improved and I did not see case again until April 5th., when I found pigmentation on hands and neck, salivation, intense sore mouth, diarrhœa and extreme nervousness and weakness. Started soamin, five grains every other day. In a week mouth healed, two weeks diarrhœa checked and pigmentation was fading. Completed the course May 26th. when all symptoms were relieved except weakness and nervousness. Saw case again on the 4th. inst., pigmentation returning on hands, also around eyes, complains of dryness of eyes, secretion of tear ducts much diminished, asthenia. His family say that he is flighty and shows decided mental weakness at times. His family history is bad, one of his children showing idiocy, another melancholia and another hysteria. History of sunburn for three years.

R. B., black female, age forty-nine, has been under my treatment for two years intermittently for intense night headaches, occipital in character. Relieved by large doses of iodide, also used soamin. Came into my office on May 1st. with slight pigmentation on hands, extreme nervousness, weakness and weak vision. Gave soamin, five grains every other day—have given about eighty-five grains and all symptoms improved but still weak and nervous.

J. H., mulatto, female, age thirty, sepecific history. Have treated her intermittently for several years for persistent headache and rheumatism. Soamin twenty grains during the winter. June 5th. came into my office with slight pigmentation of hands and headache— no other symptoms. Received eighty grains of soamin up to date. Pigmentation completely faded, feels perfectly well.

W. T., black male, age fifty, saw June 3rd. Complained of salivation and salt taste in mouth. Hands and forearms and neck pigmented, lips and mouth much inflamed. Treatment has been interrupted by intercurrent attacks of malaria. Only forty-five grains have been given but there is considerable improvement of all symptoms. This patient had never been affected with sun-burn before but for three summers past had felt nervous and weak.

E. F., black female, age thirty-five, saw June 8th. Had been under treatment for two months for dysentery, also has large uterine fibroid. On examination found raw and ulcerated condition of vulva, burning pains, pigmentation on both breasts, weeks later. Received fifty-five grains, very little improvement so far, dysentery only partially controlled by bismuth and opium. Has gained some strength and appetite.

F. W., mulatto female, age thirty-five, saw June 26th. Mouth sore, weak, nervous, back of hands pigmented, butterfly on face for past three summers. Fifteen grains—all lesions fading, mouth well, much stronger and better.

Have two other cases on hand but they resemble the above in symptomatology and treatment.

Personals.

Dr. J. James of Tomnolen has moved to Ackerman.

Dr. R. E. Higdon of Brookhaven, a prominent and valued member of the Tri-County Society, has gone to San Antonio, Texas.

MISSISSIPPI MEDICAL MONTHLY.

E. F. HOWARD B.S., M.D., Editor and Publisher.

S. MYERS M.D., Business Manager.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

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If the success of the meeting of the Association to be held this month can be estimated by the quality of the program, we should feel confident of an exceptionally interesting and instructive session. Our own men have come out in good style to the support of the chairmen and the visitors are men of recognized ability who are treating of subjects concerning which they have unusual information. Altogether we may expect good results.

An unusual feature will be noted in opening the section on hygiene to the public. Dr. Rowan, the chairman, had secured a list of papers more interesting to the layman than any in recent years, at least, and the committee was of the opinion that the opportunity to help along the lines on which the State Board Of Health has been working, in educating the people, is too good to be lost. Some little adjustment was necessary, since two or three of the papers in the section were not calculated for popular addresses, but Dr. Rowan kindly consented to transfer them to other sections and limit his program to popular education. By this it is not meant that the program will not contain any pabulum for the doctor for some of our ablest and most interesting writers are included and their papers are on subjects concerning which every physician is interested, among others the man of all others who draws and holds the crowd: Dr. Sutherland. As this educational meeting is strictly along the lines on which the old State Board has been working, the committee requests that each member of the new Board to be present and add to the effectiveness of the meeting by taking part in the discussions for there probably will be no other such opportunity to enlist the physicians of the state in this work.

An injustice was unintentionally done one of our friends in the legislature in last month's discussion of the passage of the practice act that we wish to correct. On page 227 appeared a list of members "opposed to the bill" and in it is the name of Mr. Doolittle of Newton County. This list referred to the vote taken on Mr. Simmon's motion to table Mr. Pittman's motion to reconsider the bill, which had passed the House by a respectable majority. Tabling the motion to reconsider was equivalent to killing all opposition, so those members voting against the motion to table were naturally considered "opposed to the bill." As a matter of fact Mr. Doolittle was one of those who voted for the bill on its first passage and Drs. Glass and Cooper and Mr. Robertson, the clerk of the House, assure us that Mr. Doolittle was one of our chief helpers. His vote against the motion to table was either cast under a misapprehension or wrongly recorded as the following letter shows:—

MISSISSIPPI HOUSE OF REPRESENTATIVES
JACKSON, MISS.

OFFICE OF CLERK

March 7, 1912.

DR. E. F. HOWARD,
Vicksburg, Miss.

DEAR SIR:—

My attention has just been called by Mr. Doolittle to an article in your journal regarding his vote on the Medical Practice Act—S. B. No. 95—in which you publish him as being "opposed to the bill."

The record of the vote on this measure shows that on February 14th, 1912, when this bill was before the House for passage Mr. Doolittle was one of those who voted in favor of its passage.

On Feb. 22, 1912, when Mr. Simmons' motion to table Mr. Pittman's motion to reconsider said bill was placed Mr. Doolittle is recorded as voting *no* on said motion to table. Mr. Doolittle was recognized all the way through as one of the strongest supporters of this bill; hence it is evident that some mistake was made; either I recorded his vote wrong *or* he misunderstood the question on which the vote was taken, thinking it was on the motion to reconsider in which event, as a friend of the bill, he would have, of course, voted No.

I am,
Yours truly,
STOKES V. ROBERTSON.

We regret very much that Mr. Doolittle's name should have appeared in the wrong column and assure him that we appreciate and thank him for his support.

Dr. H. M. Folkes has again assumed control of the Biloxi Sanatorium, Dr. Card having left the institution, and will operate it on the same successful lines as formerly.

Dan'l J. Williams.

Dan'l J. Williams was born in Lawrence County August 16th. 1868. He attended the public schools and worked on the farm until sixteen years of age, when he entered Mississippi College, Clinton, where he remained until the completion of the junior course. He then began the study of medicine, graduating from Tulane in the class of 1890 and being licensed in the spring of the same year.

Dr. Williams first settled at Moss Point, but in the summer of 1891 he was appointed quarantine officer at Ship Island and at the close of the quarantine season moved to Chicora, where he had been offered a contract practice, but, believing that such practice was in violation of the ethics of the profession, he gave up this work in 1893 and settled in Ellisville where he has lived until recently, when he moved to Gulfport, where he will do a general practice and be the chief medical director of the South Continental Insurance Company.

Dr. Williams has for a number of years been an active worker in his county and state medical organizations and few have been more active than he in their efforts to promote the interests and general welfare of the profession of the state. He was elected a member of the council when it was first created in 1903 and served continuously until 1911, the year of his election to the presidency, being chairman of the body for several years. This constitutes the record for continuous service on the council. He also served for three years as delegate to the American Medical Association.

In 1907 he was chosen one of the five members of the State Board Of Health elected by the Association, and in 1911 was elected president without opposition, a distinction none of his recent predecessors have enjoyed. At the recent meeting of the Southern Medical Association, in Hattiesburg, he was chosen second vice-president.

Dr. Williams has always enjoyed a good practice and commanded the respect of the community in which he resided. He has never married, but makes his home with his mother and sister Mrs. Dora W. Howell of Gulfport, to whom he is devoted.

DeSoto County Medical Society has enrolled every eligible physician in the county except one. The officers for 1912 are J. M. Wright, Hernando, president; A. J. Weissinger, Hernando, secy-treas.-treas.-delegate.

Society Proceedings.

Clay-Lowndes-Oktibbeha County Medical Society met at Artesia March 28th. and discussed the following program:— "Report Of An Unusual Case Of Hernia," W. I. Ervin; Symposium on Cerebro-Spinal Meningitis, papers by W. D. Hubbard, H. L. Scales, J. W. Lipscomb and A. L. Mason.

E. Lehmberg.

Clarksdale and Six Counties Medical Society will hold its semiannual banquet, and meeting, at Clarksdale March 27th., beginning at 2 p. m. and ending in time for the first daylight train next morning. The scientific program is good, the gastronomic is better. Physicians residing in the six counties are requested to note that the combined annual dues of the Clarksdale and Six Counties Society and the State Association is five dollars. If you have not yet paid please send your check at once to the secretary. Something may prevent your coming to the meeting. These things sometimes do happen. If you are not a member please send your application along with the dues.

T. M. Dye.

Lamar, Marion and Pearl River counties have pooled their interests and applied for a Tri-County charter. The president of the infant organization is Dr. W. Locke of Carriere and the secretary Dr. W. W. Hall of Lumberton.

Book Reviews.

THE "WELLCOME" PHOTOGRAPHIC RECORD AND DIARY, 1912. Burroughs, Wellcome & Co., 35 West 33rd. St., New York, N. Y. Price 50 cents.

This little book quite comes up to the standard of all the "Wellcome" productions and will be found a very great help to anyone in solving questions photographic. From actual experience the reviewer knows the relability of the advice offered in the question of correct exposure, one of the principal stumbling blocks of the amateur photographer.

The book is recommended to anyone interested in photography.

M. H. Bell.

PRACTICAL MEDICINE SERIES. comprising ten volumes on the year's progress in medicine and surgery. Vol. IX, Skin and Venereal Diseases, Miscellanous Topics, edited by W. L. Baum M.D. and H. N. Moyer M.D. Price $1.25. Vol. X, Nervous And Mental Diseases, edited by H. T. Patrick M.D., Professor of Neurology in the Chicago Policlinic, etc., and P. Bassoe M.D., Assistant Professor of Nervous and Mental Diseases in Rush Medical College. Price $125. The Year Book Publishers, 180 N. Dearborn St., Chicago.

These little volumes, in the full series, constitute the most convenient year book published.

E. F. Howard.

PRACTICAL ELECTRO-THERAPEUTICS AND X-RAY THERAPY. By J. M. Martin M.D., Professor of Electro-Therapeutics, Medical Department, Baylor University, etc. C. V. Mosby Co. St. Louis, Mo. 1912. Price $4.00.

A practical work on electro-therapeutics and the X-Ray written not so technically as to be above the comprehension of the average physician, and omitting all abstruse theories has long been a desideratum by the medical profession. Dr. Martin has produced just such a work, and it deserves to be widely read. The first few chapters are devoted to explaining electromotive force, magnetism, controlling and measuring apparatus, thus laying the foundation for an understanding of what follows. The X Ray apparatus is next fully described, then follows an outline of the various forms of nerve paralysis, and the technique of the electric treatment of the same. The chapter on the high frequency currents now coming into general use is very good. The second half of the book is devoted entirely to the X Ray, its use in fractures, dislocations, foreign bodies, concluding with a chapter on the medico-legal aspect. The only fault we can find is the mixture of excellent illustrations with the author's sketches, as of his X Ray plate cabinet, which distinctly mars the book.

S. Myers.

INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Articles. Vol. IV, Series 21. J. B. Lippincott Co., Philadelphia. Price $2.00.

This volume of the popular quarterly contains one article that should be the cause of every physician purchasing it, a short pen sketch of Edward Jenner, supplemented by the use of his likeness as the frontispiece. We are too prone to pass by the men who have made modern medicine possible and of these none is greater than Jenner. The scientific articles are well

chosen and are further supplemented by one on legal medicine and two on medical economics. In these respects the "Clinics" is getting decidedly more interesting and of much greater value.

E. F. Howard.

OPERATIVE OBSTETRICS, INCLUDING THE SURGERY OF THE NEWBORN. By Edward P. Davis M.D., Professor of Obstetrics, Jefferson Medical College, Philadelphia. Octavo volume of 483 pages, with 264 illustrations. Philadelphia and London: W. B. Saunders Company, 1911. Cloth, $5.50 net.

The recent advance in obstetric surgery is the reason, given by the author, for the book under consideration, but in spite of the fact that this advance is unquestionably very great Dr. Davis has had a hard time of it in making a book that will be attractive to the general run of physicians. In order to fill up he has had to recapitulate the special anatomy, that is ordinarily given more satisfactorily in ordinary obstetric texts; to discuss operating rooms, sterilization and antisepsis; to bring in gynecological and surgical procedures that are only related to the subject of the text in that they are occasionally done during pregnancy; to dig up and discuss at considerable length such antiques as symphysiotomy and pubiotomy; and even to circumcise the baby. There is quite a good deal of real obstetric surgery in the book, but most of it can be found elsewhere, and the volume as a whole, though composed entirely of good material, inspires the query: "What's the use?"

E. F. Howard.

HOSPITAL MANAGEMENT. A Handbook for Hospital Trustees, Superintendents, Training School Principals, Physicians, and All Who Are Actively Engaged in Promoting Hospital Work. By Charlotte A. Aikens, formerly superintendent of Columbia Hospital, Pittsburg, etc. Illustrated. Philadelphia and London: W. B. Saunders Company, 1911.

This little book is, as its title indicates, a handbook of hospital management and has its various chapters written by different authors thus giving expert news on the different subjects treated of. The work is certainly a mine of usefulness to all who are interested in hospital management, being the first work in the English language to treat fully of the small or hundred bed hospital. It aims to be practical and should be consulted by all who aspire to rule the institutions it treats of.

S. Myers.

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